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ABSTRACT

This handbook explores the dynamics of crisis and the alternatives available to school psychologists in working with students, teachers, and parents. The materials contained in this manual are designed to help direct the school psychologist to other support services in the school and community. The role of the school psychologist in confronting crises is explained, problems facing children and adolescents are examined, and suggestions for interventions by psychologists are given. Assessment issues in crisis interventions are discussed and physical, emotional, and behavioral signs of crisis are listed. Physical and behavioral indicators of various types of child abuse and neglect are also listed. Several structured assessment interview formats that may be useful in assessing a child in a crisis situation are explained and instruments developed to assess family stress are discussed. School psychological services to children in crisis are reviewed with discussions centering on instances in which children were referred to psychologists for immediate action. Crisis situations are described in the areas of sexual abuse, suicide and suicide threats, psychosomatic complaints, and family problems. The technique of life space interviewing is described and steps in the interviewing process are given. Crisis management in rural areas is considered. The handbook concludes with an annotated list of additional resources for the school psychologist, an extensive reference list, and appendices which contain information on incest, sexual abuse, and the life space interview. (NRB)

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CRISIS INTERVENTION

Guidelines for the School Psychologist

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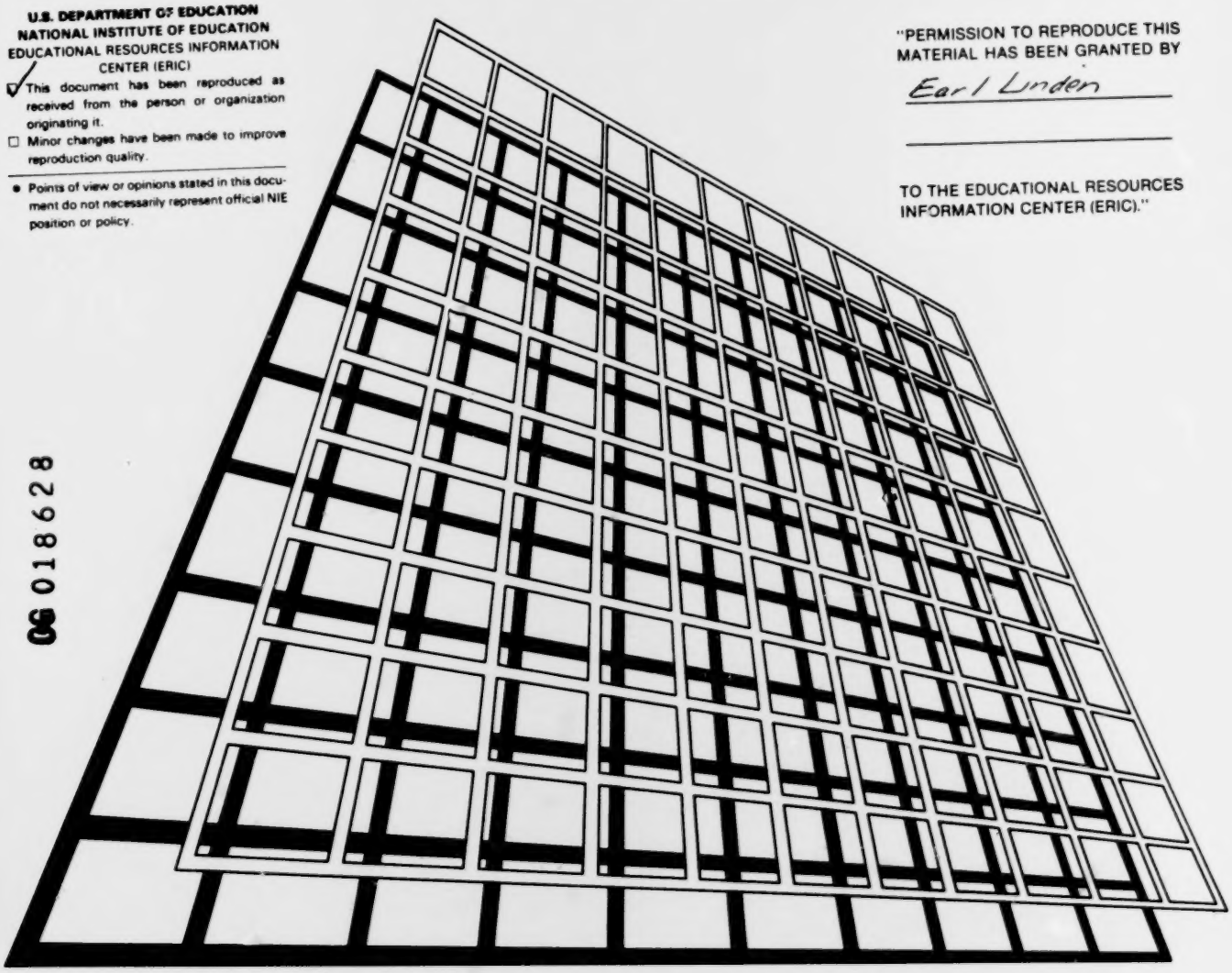

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CRISIS INTERVENTION HANDBOOK

STEWART EHLY

School Psychology Program University of Iowa

September 1985

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Introduction to Handbook and Videotape

School psychologists are confronted daily with a variety of demands for their professional service. When these demands involve situations that require quick action, the boundaries surrounding the normal functioning of the school psychologist may be altered. What can be done under these circumstances by the school psychologist is often times not readily apparent. To assist professionals in confronting crisis situations, the following handbook and accompanying videotape will explore the dynamics of crisis and the alternatives available to psychologists in working with students, teachers, and parents.

The materials will be consistent in their overall orientation. The psychologist will not be cast as a "lone ranger" expected to solve any and all problems. Rather, the professional will be directed towards other support services both in the school and the community to deal with any of a number of situations. The expectation is not that the school psychologist will solve every problem, but instead will assist in the management of problem situations.

Before any professional can be perceived as effective in dealing with crises, he or she must be aware of personal strengths and weaknesses. The professional uncomfortable in dealing with certain types of situations will still be responsible for helping people locate appropriate services. For school psychologists, correctly linking children in need with people delivering support services can be a primary function. With this orientation in mind, the following materials have been developed.

Introduction to Video Materials

A collection of episodes on crisis intervention strategies by school psychologists has been developed in support of the following written materials. Video content documents an overall orientation towards crisis situations, outlining in brief the options available to professionals as they deal with children. Video materials are not meant to represent ideal conditions for the psychologist or the referred student. On the other hand, the content and outcomes of the episodes are intended to illustrate individual strategies or skills that have been used by psychologists who assisted in the production. The materials represent the input of the three psychologists depicted on the video. Mars Edwards, Cathy Edwards, and John Hartson contributed their time and energies to the development of their individual segments. Students depicted on tape are actors who have not faced the particular crisis that they are dipicting. However, they have used their considerable talents to illustrate crisis situations that children present to psychologists in our schools. The viewer of the videotape is encouraged to weigh the strategies on the tape in light of his or her own patterns of serving children. Some of the skills depicted will not work in your own service setting. Given that transfer of these skills may be limited to the circumstances depicted, the professional viewer can still judge the validity of the general orientation to crisis that the psychologists are illustrating.

Information on the individual strategies or the specific content is provided later in this handbook. More extensive information about crisis strategies, types of problems often seen by professionals, and tactics by which outsiders are involved will be explained in detail. Viewing the tape is not necessary to profit from this handbook; however, the tape and handbook do complement each other and are useful for the professional interested in self-study centering around crisis issues.

Role of School Psychologists in Confronting Crises

In the recent Best Practices in School Psychology (Thomas and Grimes, 1985), the topic of crisis intervention is discussed by Valerie Smead. Smead (1985) recognizes the importance of the proactive professional reaching out to assist students and teachers in need. While the notion of prevention may seem contradictory to the interest in crisis intervention, the professional psychologist can view services delivered to a child in need as preventing future problems. Caplan (1964, 1970) has played a major role in documenting the validity of dealing with people in need to prevent future problems. Smead recognizes the importance of intervening when people are under stress to achieve effective, eventual adjustment.

Before proceeding to review options available to school psychologist in crisis intervention, definitions of critical terms must be established. Crisis intervention has been defined by Hafen and Peterson (1982) as "psychological first aid that enables you to help an individual, group, or family experiencing a temporary loss of ability to cope with a problem or situation." The definition recognizes that, at best, intervention can be only the most immediate interaction that you have with a child in crisis. First aid and long-term care do not necessarily go with each other. Instead, after psychological first aid is delivered, the school psychologist can determine the best strategy for the long-term care of the person in crisis.

Temporary loss of ability to cope with a problem situation may reflect any of a number of issues in the person experiencing crisis. The notion of coping is generally discussed at the same time as the notion of stress. Stress can be viewed in any of a number of ways which will influence the manner in which an intervention is created and implemented. Cox (1978) has defined stress as "a perceptual phenomenon arising from a comparison between the demands on a person and his ability to cope. An imbalance in this mechanism, when coping is important, gives rise to the experience of stress, and to the stress response. Coping is both psychological (involving cognitive and behavioral strategies) and physiological. If normal coping is ineffective, stress is prolonged and abnormal responses may occur." (page 25)

Coping represents the strategies by which the person under stress can return to more normal functioning. In a crisis situation, stressors must be addressed. Models that depict the relation of stress and coping in crisis have been proposed in a number of writings. Stensrud and Stensrud (1983) have proposed a model of stress management. This model (see Table 1) is relevant to the school psychologist interested in dealing with crisis issues.

The model depicts the relation between locus of control and the perceptions of the person being effected by any of the number of stressful events. The person under stress is seldom able to logically and consistently evaluate all options to dealing with the problem. Ineffective coping, in other words situations that can escalate to crisis, involves threatening or harmful situations that can be perceived as uncontrollable. "I am helpless" and "I will use defense mechanisms to cope" are two internal verbalizations that can be associated with ineffective coping. In contrast, "I can avoid or escape this" and "I can change myself" represent effective coping responses, according to Stensrud and Stensrud (1983). Although their model is a beginning attempt towards understanding people under stress, the authors have provided a useful perspective in conceptualizing the relation between locus of control and the expectancy of people in reacting to environmental stresses. The authors argue that ineffective coping can harm the person physiologically (e.s., high blood pressure) in addition to the more psychological impact that is evident to an observer. In this handbook, evidence of the physical harm that can be seen as related to crisis situations will be apparent in some case studies.

Kagan (1983) notes that "the consequences of an event are dependent on the structural readiness of the organism". In other words, the young child exposed to a particular event will often react very differently from the older child experiencing a similar situation. The psychologist dealing with the events that appear very similar for two children must consider many more factors than the immediate circumstances themselves before deciding on strategies for assistance. Age of a child, emotional stability, past history of coping are all issues that will effect our decisions for professional service.

Maccoby (1983) has argued that the younger the child, "the greater the importance of environmental structure in reducing the child's vulnerability to behavioral disruption under potentially stressful conditions." Events in the environment will indeed

Table 1

Coping Strategy Options

			Passive-avoidant				Cognitive Palliation				Active				
Locus	Stability	Appraisal	Resignation	Denial	Withdrawal	Detachment	Intellectualization	Rationalization	Complementary Projection[a]	Supplementary Projection[b]	Search for Information	Worry[c]	Mastery	Mental Rehearsal	Example
External	Stable	Harm-loss	X												Death of loved one
		Threat		X											Innoculation-dental work (pain)
		Challenge									X				Environmental stressors, i.e. pollution
	Unstable	Harm-loss			X										Divorce
		Threat				X									Prejudice
		Challenge										X			Severe weather
Internal	Stable	Harm-loss					X								Aging
		Threat						X							Male pattern baldness
		Challenge											X		High blood pressure
	Unstable	Harm-loss							X						Acute illness
		Threat								X					Mid-life crisis
		Challenge												X	Type A behavior patterns

[a]Complementary projection refers to the projection of intent onto some external source. "I felt hurt because that person *meant* to hurt me."

[b]Supplementary projection refers to the projection of similar experiences or affective states onto peers. *"Everybody* hated that test."

[c]Worry in this sense is similar to mental rehearsal, except that worry refers to the creation of totally negative consequences. Mental rehearsal refers to a more "objective" creation of both positive and negative consequences.

From R. Stensrud and K. Stensrud (1983).

BEST COPY A.

have a different impact on children the younger we consider them. Providing structure under potentially stressful circumstances might alleviate or prevent full expression of adjustment difficulties. As we later consider specific instances of crisis, note the potential for an intervention early in a stressful situation and the possible impact by modifying environmental structure.

Maccoby also notes that stressful events affect the younger child by causing a greater likelihood of extensive behavioral disorganization. Without the specific experience of dealing with related events and the maturity that often comes with successful past coping, the young child cannot be expected to cope successfully without our assistance. As the child increases in age, coping skills become more established. The parent, with the child's developing age, may function less as a barrier to the experience of stressful events and become a support person among many others, such as peers. As the child achieves adolescence, peers become even more important. The child who has moved away from a school to a new community reacts much differently when he or she is a teenager rather than an elementary school student. Services to children under stress will often work effectively when delivered to the entire family.

The importance of coordinating services to the child and family has resulted in models for dealing with family stresses. In the ABCX model developed by McCubbin and Patterson (1981), the period of crisis is considered to be surrounded by a pre-crisis and a post-crisis period. During pre-crisis, the stressor is considered to interact with both the family's resolve in meeting crises and the definition the family makes of the event. The original version of the pre-crisis model was proposed by Hill (1958). As the stressor interacts with resources and the perception of the stressor, the crisis can then be confronted. Mcubbin and Patterson propose consideration of post-crisis variables, which include (1.) additional life stressors and changes which make the family's adaptation more difficult; (2.) critical psychological and social factors that families can call upon and use in managing crises situations; (3.) processes that families can engage in to achieve satisfactory resolution; and (4.) the eventual outcomes of family efforts. Thus, the ABCX model pulls together issues of stress, coping, and crisis into one package. As we will discuss later, the authors have developed some assessment instruments that can assist professionals in documenting the stress and coping of family members.

Direct Interventions by School Psychologists

A major function of professional school psychology is the delivery of direct services to children. As Grimes (1981) has stated, there are several key elements to school psychological interventions: (1.) results from a plan based on sound psychological theory and research; (2.) differs from special education and other instructional/managment placement decisions; (3.) involves the identification of behaviors for change; (4.) may focus on a wide range of target behaviors including education, social, and personal problems. The professional psychologist is prepared to provide direct survices under a variety of conditions. When those conditions include extreme problems of stress and coping, or crisis periods, expertise of the professional may be less extensive.

Medway (1985) has stated that interventions to children by school psychologists often must be built on little research knowledge. Medway argues that there is a serious gap in the research literature in terms of psychological services to deal with specific treatment issues. Literature on adult problems, while much more extensive, may not transfer to working with children and youth. Because of this gap in knowledge about children, school psychologists must review the broader literature on social functioning and supportive interventions to develop the basis for any form of crisis assistance.

Spillane-Grieco (1984) has described the role of empathic understanding and positive regard in working with children and parents experiencing one type of a crisis, that of running away from home. An exploration of the author's scheme for assisting runaways provides a context to consider related crises. Spillane-Greico acknowledges that economic circumstances and the broader social mileau have an impact on pressures experienced by children in the home. Support that parents can provide often times is influenced by the physical realities of substaining a family life. When children cannot cope with the environment in the home, whether physical or social, there are methods by which a professional can assess the skills of children and parents in terms of relationships. Empathic understanding refers to the ability to put oneself in another's place and to perceive the world as that person does. Positive regard denotes the ability to give and receive positive feelings. In some studies of runaways, families of adolescents who did indeed leave home had

less empathic understanding and postive regard than did families who did not experience runaways. Basic communication skills were practiced incorrectly or not at all in many homes having runaways. Similar problem situations have been documented in the families of other students who have been referred to juvenile authorities or mental health services. We have a better understanding now then in the past of how communication skills are basic for the functioning of effective families. School psychologists are critical resource persons, because of their professional status, to families. They more readily than other professionals can assess difficulties experienced by children in coping with demands in their environments. They are also in the position to select additional services for children and their family.

School psychologists, while in a strategic position to provide services to children in crisis, have the choice to respond in a variety of ways to any event. Reynolds, Gutkin, Elliott, and Witt (1984) state that school psychologists operate under specific assumptions that influence the type of intervention they provide. Psychologists can choose to react proactively or reactively to a specific event. Under situations of extreme crisis or emergency, reactive interventions may appear to be the only alternative. Providing a specific direct service may appear to be the only feasibile avenue to assisting a child. Proactive interventions, on the other hand, represent a reaching out of the professional to manipulate circumstances and events that will have a later impact. Many actions of school psychologists will have elements of both proactive and reactive services. The school psychologist who perceives himself or herself as a crisis manager will adopt a proactive attitude committed to influencing the lives of children and teachers and supporting more successful coping.

Another dimension of services to children in crisis is the direct versus the indirect service choice. Direct services involve working with the child or the family to assess events, develop possible strategies for confronting the crisis, and implementing a specific plan of action with long term consequences. The indirect route to service is a feasible alternative also. Consulting with the classroom teacher, school counselor, or community mental health professional, the school psychologist can develop a team of professionals to assist the child or the family in crisis. The growth of interest in consultation services reinforces consideration of the indirect service route to dealing with crisis events.

Reynolds et al (1984) consider a final choice point for the professional. Specific versus global interventions can be considered in dealing with the child. During crisis, a specific intervention is warranted if the professional is working to eliminate events or behaviors that contribute to the perceived crisis. For example, the child who is being sexually abused will not be processed by the psychologist for placement into a special education program. Instead, the professional will work, often under mandates for reporting, to directly place that child with professionals who can either remove the child from the home or provide support services to intervene directly into the family.

The options available for intervention in any situation are many and varied. Reynolds and Gutkin (1982) have collected a wide array of service alternatives. Many of these are directly relevant to the professional dealing with a crisis event. This handbook will explore those interventions that have been used during particular crisis events. As expected, behavioral interventions have achieved wide popularity. Service alternatives based on mental health theories also have been popular. More recent ecological orientations have dictated a focus on entire family or environmental systems. Regardless of the choice of an alternative, there are methods by which strategies can be evaluated. Reynolds et al (1984) propose 4 dimensions by which to accomplish such evaluations: Acceptability, effectiveness, cost, and treatment integrity. Effectiveness of a treatment approach can be documented through formal evaluation or controlled research. Whether or not an intervention works, of course, is a critical issue for the continued use of that intervention option. The school psychologist is one of the few professionals in the schools trained to conduct ongoing evaluation of treatment effectiveness. Documentation of attempts can coincide with more formal consideration of the impact of an intervention.

Acceptability of an intervention can be considered as the face validity of that intervention. An additional consideration will be whether or not the treatment is considered appropriate to a given problem, whether or not it's fair, reasonable, or intrusive, and whether it's consistent with notions of what a treatment should be (Kazdin, 1980). Acceptability cannot readily be an issue of consensus unless the professional has from the start worked with colleagues and parents on an intervention option.

Cost effectiveness tends to incorporate notions of time, materials, and energy in delivering a particular intervention. Under conditions of crisis, cost effectiveness considerations are generally not critical. The time involved and the need to achieve ready closure dictate rapid progression towards treatment objectives. Long-term commitment to change, however, may involve a much more expensive array of interventions. Referral to outside services, for example, can be very expensive if such services are medical in nature.

The final consideration, treatment integrity, relates to the notion of the continuation of an intervention to a successful completion. When a treatment has not been implemented as intended or has been implemented incompletely or inconsistently, treatment integrity cannnot be certified. The school psychologist is expected, upon proposing an intervention, to have the expertise in conducting such an intervention or to direct other professionals to deliver such services. During crisis intervention, the notion of treatment integrity is an important one. Psychologists unfamiliar with the issues related to a specific form of intervention must ethically direct the child, parents, or school to the most appropriate services. The APA and NASP code of ethics deal with the responsibilty, competence, and confidentiality standards that are integral parts of any strategy to effect change. Failure to integrate such ethical principles into the actions of the school psychologist is a critical omission.

School Psychological Services in Rural Areas

Attention to the needs of students living in rural areas has uncovered the relative gaps in services existing in our country. We are unclear, as Berry and Davis (1978) have discussed, on the full extent of the difficulties in providing mental health services in rural areas. These authors have documented the inability of mental health professionals in being fully responsive to the goals and needs of the rural client. Rural families and their children are similarly often unresponsive to the goals and needs of the mental health professional. Barry and Davis argue that professionals who do not come from rural backgrounds are seldom able to identify with the lives of their clients, while these clients are seldom aware or responsive to psychological models of functioning.

Rural as a designation includes country, farm land, small towns, and outlying areas. The problems faced by rural children in terms of available services can differ according to the type and characteristics of the rural area. Lack of adequate resources, population scatter, problems in transportation, and contrasting definitions of problem behavior can be faced by mental health professionals. Fagan (1981) has discussed problems faced in the delivery of school psychological services in such areas. Fagan cites the difficulty in finding and retaining qualified staff to provide such services. Services in rural areas are often times expensive to deliver. Geotz and Doerksen (1978) have discussed the long distances and travel conditions associated with serving rural childres. Schools are often forced to subsist on irregular schedules that lack the immediacy of confronting problems in the schools. When crisis events occur in rural area, this factor of immediacy is an important consideration. School psychologists responsible for service in rural areas must have a network of support persons to back up such services when the professional is not in the area. The rural perspective on crisis intervention will be discussed in greater detail later.

Problems facing Children in Adolescence

Children experiencing difficulty in adjusting to the demands in their lives may fail to adequately cope at any given point. As we discussed earlier, younger children may be inadequately prepared to deal with events occurring around them. Chandler (1982) reviewed some major sources of stress associated with childhood. Failure to cope with major stressors can lead to a crisis situation. Common stressful events include peer relationships, school, death of a loved one, divorce of parents, or hospitalization. Literature on each of these factors associated with stress has been developing. Indeed, we have textbooks documenting cases in which children have been confronted with circumstances requiring professional intervention. Millman, Shaefer, and Cohen (1980) and Stein and Davis (1982) are two examples of manuals depicting effective interventions with school-based problems experienced by adolescents.

Chandler (1982) writes that a child's response to stress depends on their personality, circumstances surrounding the crisis, and what has worked in similar situations in the past. Two dimensions of personality that can be used to describe behavioral responses are an active-passive dimension and an introverted-extroverted dimension.

Patterns of response to stress may be broken up into four areas: (1.) The dependent response can be adopted by children who are often passive and immature. When placed in a stressful situation, they may become immature in their speech and behavior and act silly. They can be characterized as lacking independence in most areas of functioning; (2.) The impulsive response is adopted by a child who is readily excitable and restless. Such a child may appear inattentive and distracted in school; (3.) The passive-aggressive response is used by children who are often characterized as underachievers and indifferent to their grades. They may appear obstinant and uncooperative and tend to procrastinate; (4.) The repressed response is adopted by children who are typically quiet and reserved. They may fail to initiate conversation and appear to be daydreaming.

The complexity of a child's personality as it interacts with stressful events indicates that the school psychologist will be most effective with a child in crisis when that psychologist is familiar with the child's past cycle of coping. Failure to understand common patterns in a child's behavior can lead the psychologist to misread or misunderstand the functioning of the child.

In considering the problems faced by children or adolescents, the professional practitioner begins by reviewing knowledge about the development of children's social, emotional, physical, and cognitive domains. A sound understanding of a child's growth and development enables the professional to understand when a child is functioning at less than optimal levels. While it is easy to name specific problems that come to the attention of psychologists (e.g. sexual abuse, runaways, suicide), it is much more difficult to have a grasp of critical dimensions by which the psychologist can understand and plan for the child's ongoing growth and development.

Clearly, adequate information about ongoing problems is important. Under situations in which the child is in crisis, however, the need for valid information is heightened. Before we consider potential strategies for collecting information, a review of specific proposals for the discussion of crisis events will be considered. Aguilera and Messick (1974) have listed (See Table 2) the differences between the general types of interventions that can be used during a crisis and those used during interventions independent of emergency events.

Table 2 illustrates that crisis intervention differs from psychoanalysis and brief psychotherapy in the need for a quick resolution of the immediate crisis. Treatment generally focuses on the present rather than delving more deeply into the past of the individual. Secondly, restoration to a level of functioning that coincides with past functioning is a critical goal or focus. Psychoanalysis and brief psychotherapy are much more concerned with past events at the conscious and unconscious levesl.

The therapist or psychologist takes a much more direct and active stance with the child. Treatment is obviously much quicker in response to a crisis. Aguilera and Messick (1974) have proposed steps in crisis intervention that can be considered here. The two authors propose that the person under stress be assessed using techniques that focus on current functioning. The authors similarly argue that any intervention must be based on an

Table 2

	Psychoanalysis	Brief psychotherapy	Crisis intervention
Goals of therapy	Restructuring the personality	Removal of specific symptoms	Resolution of immediate crisis
Focus of treatment	1. Genetic past	1. Genetic past as it relates to present situation	1. Genetic present
	2. Freeing the unconscious	2. Repression of unconscious and restraining of drives	2. Restoration to level of prior to crisis
Usual activity of therapist	1. Exploratory	1. Suppressive	1. Suppressive
	2. Passive observer	2. Participant behavior	2. Active participant
	3. Nondirective	3. Indirect	3. Direct
Indications	Neurotic personality patterns	Acutely disruptive emotional pain and severely disruptive circumstances	Sudden loss of ability to cope life situation
Average length of treatment	Indefinite	From one to twenty sessions	From one to six sessions

From D.C. Aguilera & J.M. Messick (1979)

accurate assessment of the event that precipitated the crisis. Aguilera and Messick propose helping the individual to gain an intellectual understanding of the crisis facing them. For the child, however, school psychologists may be less concerned with intellectual understanding than in eliminating any immediate stressors that can interfer with general functioning. The authors also recommend helping the individual express feelings about stressful circumstances that lead to the crisis. As we shall see, many authors more familiar with services to children make similar recommendations.

Auguilera and Messick continue by recommending exploration of the coping mechanisms and encouraging supportive relationships. Such recommendations are consistent with what we know is useful in serving children.

Of related interest are the recommendations of Hipple and Hipple (1983), who have developed a guide for mental health professionals dealing with hospitalization of clients. Hospitalization in and of itself is a stressful event and can precipitate a crisis response. According to these authors, a crisis occurs when a usual coping style is no longer adequate in meeting the demands that an individual must face. For children, as we have documented, coping styles are either nonexistent or are tentative at best. Two major categories of crisis can be conceived: (1.) accidental--death, unexpected loss, fight with a loved one; (2.) situational--crisis during a particular point in life, or a crisis of a developmental stage in the life cycle. The latter category seems most applicable to adults in crisis while the former can apply to just about everyone.

Hipple and Hipple stress the importance of assessment of crisis events. They specify that the facts surrounding the crisis situation be determined to provide a framework for understanding the crisis and allowing the person to vent feelings. Who, what, where, and when questions are the tools by which such information is established. Secondly, the psychologist can help the client understand facts surrounding the crisis situation. This would be followed by assistance to the client, and includes understanding feelings and emotions related to the problem circumstances. Consistent with other models is an exploration of possible adjustments or solutions followed by identification and contacting of social supports.

More importantly, Hipple and Hipple (1983) propose actions steps by which the psychologist can assist the person under

crisis. They recommend breaking the situations down into small segments to be handled. In other words, rather than allowing the child under stress to perceive events in their entirety, the psychologist can help reinterpret stressful events in such a way that situations seem to be less overwhelming. Problems at home, for example, can be described as being problems between the individual actors rather than an intermingled web of events that cannot be extricated.

Secondly, the psychologist can help the child see the crisis situation as a challenge rather than as a threat. Although working from this direction can sometimes seem to be less than helpful, Hipple and Hipple propose that there are certain events that precipitate crisis and can be adequately handled when relabeled as a challenge. For example, problems at home, including unexpected loss of a parent, can be perceived as motivating forces that will enable the child to grow and mature into adulthood.

Next, the psychologist can help the child see his/her reaction to crisis as being very similar to that of other children facing similar circumstances. As is true about adults in crisis, children under stress often feel alone. They believe that they are the only person in the world, or at least the first, to experience a problem. When given the perspective that indeed they are not unique, many people will be comforted rather than irritated that others have faced similar problems and been able to successfully cope.

A final action according to Hipple and Hipple is to redescribe the crisis and set the stage for a plan. Crisis intervention differs from counseling because it does not assume that the clients cannot take an active stance without help and direct intervention. Counseling assumes that clients, whether they are children or adults, can articulate feelings and act rationally. During crisis intervention, however, the individual often cannot do these things. A stage must be set to assist a person to gradually assume responsibility for actions and thoughts.

In reviewing the initial proposals for crisis intervention, the reader may have noticed the similarity of such recommendations to similar proposals for managing stress. Cox (1978), for example, has proposed that stress can be managed or alleviated by attention to specific steps: Alterations of demands placed on the person from the physical and psychosocial

environment, alteration of the ability to cope, support of existing abilities to cope, alteration of cognitive appraisal of events, alteration of the actual importance of coping, alteration of the behavioral response to stress, and alteration of the physiological response to stress. Each of these adjustments to a person's coping abilities will obviously have an impact on the extent to which the situation is labeled as a crisis. Such alterations similarly have important implications for treatment or intervention with the child. For example, influencing demands of the environment, whether physical or psychosocial, implies manipulation of forces identified as important from an ecological perspective. Altering abilities to cope implies straightforward training of the person to acquire specific skills. Changes in cognitive appraisal can involve counseling or psychotherapy or the use of mood altering drugs. Physiological changes might also involve the use of drugs or the manipulation of functioning through the use of biofeedback strategies.

The use of counseling or psychotheraputic interventions with persons in crisis has been discussed by VanOrnum and Mordock (1983). The authors provide a guide to crisis counseling that emphasizes understanding of critical stages in child development. Crises reviewed include those brought about by death, divorce, illness, handicaps, child abuse, foster care and behavioral problems. The authors take a psychodynamic perspective on approaching children in crisis. The approach is associated with an empathic understanding of how child think, feel, and perceive crisis events.

Elements of a crisis for a child include differences in coping styles when compared to adults. The child must continually face new challengs when growing up. He or she cannnot rationalize the need to cope and does not know how to reduce demands that are being placed on them. Faculties for problem solving and dealing with rational thoughts are not fully developed. In contrast, adults have a sense of who they are and their purpose in life. A crisis may temporarily shake their purpose but responsibilities can continue to be met because of well established behavioral patterns. The adult can make choices not to meet responsibilities during crisis. For example, minor tasks can be put aside until circumstances are more favorable. The adult can regulate basic needs and develop strategies of dealing with irrational thoughts. Over time, the adult can gradually feel better and do more than just cope on a day to day basis.

Less intensive crisis circumstances also can elicit different adjustments from children and adults. Children often lack the verbal skills and life planning strategies that can help the adult under crisis. The child lacks the ability to communicate fears and remains in crisis by not knowing how to resolve difficulties. Adults, in contrast, can relive the crisis in their minds and create new aspirations. With problems associated with death, they may be better able to grieve than are children and to go beyond that grief to plan for the future.

VanOrnum and Mordock discuss what are called regressive acts, more primitive behavioral patterns when stress is too great. The person may act out rather than talk through a problem. In a crisis, a child may go through a variety of feelings that were experienced but left unresolved in past similar situations. Because their only resources in confronting a current problem may be based on an unresolved past conflict, children can not be expected to cope very successfully without support. The nature of upsetting events also has an impact on the child. According to these authors, upsets are distressing disturbances that have three elements: (1.) Thwarted intentions, an aim or purpose that is not achieved; (2.) Unfulfilled expectations, something that is anticipated or something that the child feels is his due but does not come about; (3.) Undelivered communications, lack of ability to think about issues and to communicate feelings about these issues.

The authors propose helping children to achieve improvements in their relations and in their adjustments with their care-takers. Part of this is brought about by looking for and reinforcing mature coping efforts. VanOrnum has several recommendations for working with children to enable them to perform in a more mature fashion.

Hafen and Peterson (1982) state that anyone can experience crisis, situations in which emotional pressure becomes so great as to reduce that person's ability to cope. Factors that percipitate crisis include the blocking of normal coping mechanisms, a problem which occurs for which a person is unprepared, and problems which occur when others are unable to help in support. Given our knowledge that children's normal coping mechanisms may be inadequately developed, crisis events may be more easily precipitated than for adults. In contrast, support for a child may be more readily available than when a similar set of circumstances is faced by adults. The parent, teacher, and interested educators may be available to assist any

child. Support for the child can come in a variety of ways. The older the child, of course, the more readily they can benefit from many forms of support.

Hafen and Peterson propose six general areas of support that service providers can deliver: (1.) Intellectual functionings-problem solving skills can be developed or supported; (2.) Interpersonal assets--having friends and family available for support; (3.) Emotional resources--ability to face problems through coping skills; (4.) Hope--reasons for living and overcoming problems; (5.) Healthy personality--combination of the first five factors; (6.) Self motivation--desire to take care of oneself.

Looking for assistance from persons sharing religious beliefs is one implication of the fourth source of support, that of hope. Reasons for living and overcoming problems are indeed basic tenets of many established religions. Support from religious groups may be available to provide assistance under other areas of Hafen and Peterson's list.

In a crisis situation, the child can be faced with either predictable or unpredictable events. Predictable events or crises often are related to stages of development. They usually allow time to make flexible and realistic plans to reduce stress and anxiety. For example, adolescents grow into adulthood, single people can plan to be married, and working adults plan towards retirement. Unpredictable events are by definition less subject to control. Natural disasters occur, accidents happen, suicide and attempted suicides occur, as well as other unexpected or tragic life experiences. In all predictable and unpredictable crises, the events themselves may be problems that lead to anxiety, confusion, or disorganized problem solving. Old methods of coping may fail or old methods may not change the continuation of a problem event. Anxiety about failure to cope may indeed worsen the overall problem. Solutions may have been tried without success so that tensions deepen. On the other hand, solutions may finally work and a crisis ends. Finally, an individual can simply give up and allow anxiety and tension to lead to depression.

Hafen and Peterson (1982) recognize the importance of bringing about change to people experiencing crisis. Their recommedations are many, but I think easy to understand. First, they state that acting quickly in coming to a person's aid is extremely important. During initial contact, the professional

can work to control a person's environment. Events that contribute to crisis circumstances or make situations worse can be eliminated by providing a protective context. When control is established, the assessment of the person can begin. Assessment is defined as gathering information to help make decisions, not necessarily the administration of formal tests.

Once the professional understands what is occurring, necessary adjustments can be made to solve the crisis quickly. With the feedback of the person in crisis, the professional can set limited goals for that person, foster hope and expectations, and assist the person to contact support systems. All elements operate to plan for the future as well as to promote a good self-image and self-reliance.

The two authors provide important information on children in crisis. They recognize, however, that work with a child cannot occur without a parent or guardian's approval unless the child's life is endangered. The authors recommend dealing with issues once the child has some rapport with the professional. Children may not understand the importance of what you are asking and not have the skills to adequately express themselves. By allowing the child time to become comfortable or getting them involved in games or storytelling, you can allow the child to be relieved of the additional pressure from too rigorous questioning.

Giving a child food and allowing comforts in the environment will contribute to letting the child relax. Keeping sessions short is important for this same reason. The authors recommend not lying to the child but helping the child to adjust to events that are painful by using honesty. Getting the cooperation of other adults is critical, especially when those adults are in the child's family. Expressing honest emotions is also seen as important. Protecting the child from negative comments from others that surround them is important during the crisis stage. The authors finally recommend not taking the child's reactions personally because the child, out of fear and anxiety, may say things that are not thought through.

An additional series of recommendations on crisis intervention has been provided by Eddy, Lawson, and Stilson (1983). While the authors focus on substance abuse and suicide, their recommendations have applicability to a wide range of crisis events. Eddy et al recommend steps to take to help a person resolve a crisis problem. Professionals can use emotional ventilation, helping the client so that emotions can be

expressed. The service provider can assist by reflecting feelings, identifying and labeling emotions, and not allowing emotional binging to take place because it may interfere with the primary goal of problem solving.

Gathering information under these circumstances involves establishing what is going on, who is involved, who the principal players are, what is being done, as well as a judgement as to immediate needs. The psychologist can assist in identifying patterns of problem development. In other words, the sequence of events that lead to a crisis can be established. By knowing what has happened before and what has helped before, the professional is in a position to make recommendation for the future.

Developing solutions to a crisis event then will proceed. Alternative plans of action can be generated and the child can assist in choosing a single plan. Taking action is important in crisis resolution,and involves the generation of lists of resources for additional help. Most important of all is follow-up. During this stage of support to the child, the school psychologist can deliver additional assistance as well as check on the impact of plans already established.

By definition, crisis intervention is a short-term process that has certain limitations of time and process. All needs may not be met within the time limits, resulting in referrals to support services. Follow-up by the school psychologist is of critical importance in ensuring the delivery of added services. As will be discussed later, management responses to crisis events can be assumed by the school psychologist. Whether or not the psychologist is assigned primary responsibility for ongoing direct services, the professional can tap community resources to deliver services in the plan of intervention. By monitoring the implementation of interventions and assessing the impact of services, the professional guarantees the proper evaluation of service delivery.

Assessment Issues in Crisis Interventions

The events percipitating a crisis are outside the control of the school psychologist. Once an event has occurred, however, the psychologist is able, if he or she chooses, to assess crisis events and children experiencing them. Such information is not

simply to satisfy the psychologist's curiosity but serves as a data base for both immediate and long-term services to a child or family. Hafen and Peterson (1982) have stressed the importance of assessing during the early stages of a crisis. Their recommendations are useful ones that can be considered in entirety.

> "Look at the situation carefully; assess what the person is telling you as it compares to the situation as you see it. Remember, the person's perception is what triggers crisis. You may think that a man is reacting beyond rationality after some neighborhood children pluck the heads off his roses; what you may not see immediately is that the man learned that morning of his wife's terminal cancer. Assess a person's general alertness and the ability to communicate by asking questions that force a response. As you talk, try to identify the cause of the crisis by asking open ended questions that call for answers; "What has happened to make you so upset?" "Why are you away from home?" "Have you recently lost someone?" "Is there a reason you need help right now." Watch the person's posture, body movements, eye movement and mannerisms. Note whether the person is disheveled, intoxicated, distracted, forgetful, abnormally depressed or euphoric, or worried." (pg.11)

While some writers may be uncomfortable with the questions proposed by the authors, Hafen and Peterson do recommend strategies consistent with proposals of other writers on crisis management. Assessment during crisis can begin immediately and continues until the professional acquires adequate information to make a decision, and secondly, information is solicited that allows the person to achieve emotional and intellectual grasp of circumstances affecting him or her.

Symptoms and signs of crisis may vary broadly across individuals. Personality and temperment considerations may determine how a person displays discomfort or apparent stress. With children, it may be even more difficult to separate situations of normal discomfort, such as injury or mild emotional upset, from more severe circumstances denoting crisis. There are several symptoms that have been proposed as signals of distress and crisis. These signs and symptoms can be broken into the following categories:

Physical signs and symptoms--
- change in appetite
- headaches (usually chronic)
- abdominal pain
- rapid breathing
- rapid heartbeat
- extreme muscle tension
- nausea and diarrhea
- weight gain
- insomnia
- ulcers
- digestive upsets
- high blood pressure.

Emotional signs--
- nervousness
- tension
- fatigue
- hostility
- anger
- depression
- ambivalence
- inability to make decisions
- panic
- crying spells or constant outbursts of temper
- irritability
- guilt
- paranoia.

Behavioral signs--
- inability to concentrate
- preoccupation with the past
- slips of the tongue
- denial
- delusions or hallucinations
- changes in habits
- demanding, clinging behavior
- withdrawal from regular activities
- excessive drinking
- drug use
- criminal or delinquent behavior
- sudden carelessness in dress in a normally well dressed person
- alcoholism

(Hafen and Peterson 1982, pgs. 15-16)

The classroom teacher is often the individual most familiar with a child's expected behavior in the school setting. When crisis occurs, the teacher may be the first person to notice any behavioral changes that may signal reaction to a crisis. Clearly, the teacher is the best single ally for the psychologist responsible for assisting children in crisis. Many times the teacher is expected to be alert to issues such as abuse and neglect of the child, as Tower (1984) has noted. The issues discussed in the Tower handbook on abuse deal with physical abuse and neglect, sexual abuse and emotional abuse. Of importance to the psychologist is Tower's description of reporting laws and the protective agencies available to provide service. The materials provided by Tower contains indicators of child abuse and neglect (depicted in Table 3).

Reporting laws on physical and sexual abuse vary by state. In Iowa, a variety of individuals is responsible for reporting to appropriate agencies all indications of such abuse. Mental health professionals, physicians, and teachers are among the groups who can notify authorities of any suspicions of abusing circumstances. Abuse may not be perceived as a crisis by the child affected. Reporting laws developed by the state recognize that the child is not the best judge of many events affecting them and authorized adults are mandated, through their professional capacity, to report to local protective agencies.

Reporting policies of states or individual school districts are based on the gathering of accurate, quick information. Such information falls into the category of assessment because data gathered will be used to make decisions affecting the child. Tower discusses some important information that can assist in decision-making regarding issues such as abuse to the child: (1.) When does the teacher or support person report child abuse or suspicion of abuse? What is reasonable cause to believe that abuse is occurring? (2.) Whom does the teacher or support person notify? In some districts the school nurse has responsibility for notifying agencies. The contact person in a local situation can vary by district. (3.) What specific information does the teacher or support person need to know in order to report? Are physical or behavioral manifestations of abuse in and of themselves sufficient or does the teacher or support person need to gather additional information? (4.) What actions should the teacher or support person take before reporting to validate suspicions? Again, in some districts, other school personnel may be notified to take action preliminary to reporting to authorities. (5.) What other school personnel should be

Table 3

PHYSICAL AND BEHAVIORAL INDICATORS OF CHILD ABUSE AND NEGLECT

Type of Child Abuse/Neglect	Physical Indicators	Behavioral Indicators
PHYSICAL contacts ABUSE	Unexplained bruises and welts -on face, lips, mouth -on torso, back, buttocks, thighs -in various stages of healing -clustered, forming regular patterns -reflecting shape of article used to inflict (electric cord, belt buckle) -on several different surface areas -regularly appear after absence, weekend, or vacation -human bite marks -bald spots Unexplained burns: -cigar, cigarette burns especially on soles, palms. back, or buttocks -immersion burns (sock-like, glove-like, doughnut-shaped on buttocks or genitalia) -patterned like electric burner, iron, etc. Unexplained fractures: -to skull, nose, facial structure -in various stages of	Wary of adult Apprehensive when other children cry Behavioral Extremes: -aggressiveness, or -withdrawal -overly compliant Afraid to go home Reports injury by parents Exhibits anxiety about normal activities e.g. napping Complains of soreness and moves awkwardly Destructive to self and others Early to school or stays late as if afraid to go home Accident prone Wears clothing that covers body when not appropriate

	healing -multiple or spiral fractures Unexplained lacerations or abrasions -to mouth, lips, gums, eyes -to external genitalia	Chronic runaway (especially adolescents) Cannot tolerate physical contact or touch
PHYSICAL NEGLECT	Consistent hunger, poor hygiene, inappropriate dress Consistent lack of supervision especially in dangerous activities or long periods Unattended physical problems or medical needs Abandonment Lice Distended stomach emaciated	Begging, stealing food Constant fatigue, listlessness or falling asleep States there is no caretaker at home Frequent school absence or tardiness Destructive, pugnacious School dropout (Adolescents) Early emancipation from family (adolescents)
SEXUAL ABUSE	Difficulty in walking or sitting Torn, stained or bloody clothing Pain or itching in genital area Bruises or bleeding in external genitalia, vaginal or anal areas Venereal disease Frequent urinary or yeast infections Frequent unexplained	Unwilling to participate in certain physical activities Sudden drop in school performance Withdrawal, fantasy or unusually infantile behavior Crying with no provocation Bizarre, sophisticated, or unusual Anorexia (especially adolescents), sexual behavior or knowledge Sexually provocative Poor peer relationships Reports sexual assault

	sore throats	by caretaker Fear of or seductiveness toward males Suicide attempts (especially adolescents) Chronic runaway Early pregnancies
EMOTIONAL MALTREATMENT	Speech disorders Lags in physical development Failure to thrive (especially in infants) Asthma, severe allergies, or ulcers	Habit disorders (sucking biting, rocking, etc.) Conduct disorders (antisocial, destructive, etc.) Neurotic traits (sleep disorders, inhibition of play) Behavioral extremes -compliant, passive -aggressive, demanding Overly adaptive behavior -inappropriately adult -inappropriate infantile Development lags (mental emotional) Delinquent behavior (especially adolescents)

Adapted from Broadhurst, D.D., Edmunds, M., MacDicken, R.A., Early Childhood Programs and the Prevention and Treatment of Child Abuse and Neglect. The User Manual Series, Washington, DC: U.S. Department of Health, Education, and Welfare, 1979. From Tower (1984).

involved, as discussed above? (6.) Who makes the report to the appropriate authority? And how? (7.) What information should be included in any formal report? Again, states can vary by the specifics of the reports that are mandated. (8.) What follow-up is expected on reported cases, whether by the school or protective agencies? (9.) What role will the school play on a possible community or child protection team? Districts may have already negotiated and established cooperative efforts between child protective agencies and school resources. (10.) What committment does the school have for inservice training or community programs to deal with such issues? In many areas of the country, issues of sexual abuse, suicide, and vandalism have elicited strong reactions from the community. On the basis of such feedback, the school and community agencies have worked closely together to establish training programs for educators, parents, and students to deal with the symptoms of such problems.

Tower (1984) argues that any suspicions of abuse can be managed by a teacher or support person by documenting and then analyzing information, consulting with other professionals, communicating with the child and parents, and preparing reports to specified agencies or personnel.

School psychologists in the role of mandatory reportor will be directed to perform specific functions to alert mandated authorities concerning suspicions or evidence of particular events. In the role of a mandatory reporter, the psychologist may perceive himself or herself to be restricted in actions that can be taken to serve the child or family. Where mandatory reporting has been established for years, professionals have recognized that such reporting serves the child's best interest and can comfortably fit with the full range of services by a professional psychologist. The collection and translation of information into a written report are functions that a psychologist has full expertise in delivering.

Assessment of problem events has been established as an important function of persons intervening into crises. King and others (1983) have described assessment that can be provided to sexually abused adolescents. As notions of service to children in crisis become better established, emphasis on assessment specific to these children has expanded. King reports on self-esteem inventories and child behavior checklists that have been used to document functioning of sexually abused children. Many other studies to be described later have reported on small projects involving children in crisis during which assessment

data were collected. While the intent of data collection at times appears to be strictly for experimental purposes, there are examples of situations in which data collection satisfied experimental considerations and provided data for change.

Paget (1982) documents the use of a structured assessment interview for purposes of defining the status of children. Paget uses Maccoby and Maccoby's (1954) definition of a structured interview as "one in which the questions have been decided upon in advance of the interview and are asked with the same wording and in the same order for all respondents." The structured interview differs from the unstructured one in being relatively inflexible in the manner in which questions are asked. While the psychologist may be uncomfortable in using the structured format during situations of crisis, the format does allow for a more reliable and valid collection of information than do the less structured approaches.

Paget discusses a wide arrange of interview strategies that have been used in the past with a variety of children sharing special characteristics. A brief discussion of some interview formats discussed by Paget follows.

The Diagnostic Interview for Children and Adolescents is described as a structured psychiatric interview to diagnose children between the ages of 9 and 17 years (Herjanic, Brown, & Wheatt, 1975). The instrument takes an hour to an hour-and-a-half to complete and incorporates demographic questions with inquiries about school functioning, relations at home, and interpersonal functioning. Sections are incorporated that deal with physical functioning, sexuality, insight, judgement, orientation, and memory.

The Screening Inventory assesses psychiatric impairment of children ages 6-18 years (Langner, Gerstein, McCarthy, Eisenberg, Greene, Harson, & Jameson, 1976). It has three sections dealing with the backgound of the child, child behavior items, and a parental section dealing with that person's behavior. The questionnaire deals with seven factors including self-destructive tendencies, conflict with parents, fighting, and delinquency.

The Mental Health Assessment Form was developed as a screening device to deal with children ages 7-12 (Kestenbaum and Bird, 1978). Developed to assess the vulnerability to pathology of children of schizophrenic parents, the instrument has been modified for use with adolescents. Areas such as drug abuse,

alcoholism and sexual behavior can be assessed on one version of the instrument.

A psychiatric interview format has been developed by Berg and Fielding (1979) to deal with a variety of issues. Aspects assessed include anxiety, sadness, tearfulness, tension, fidgetiness, poor emotional response, poor rapport, disinhibition, little spontaneous talk, and lack of smiling.

The Interview Schedule for Children was developed to assess depressive symptomatology and behavioral disturbances in 8-13 year old (Kovaks, Betof, Celebre, Mansheim, Petty, and Raynak, undated). The structured interview has been described by Paget as a promising instrument to assist assessment of depressive behaviors.

While Paget describes a variety of other structured devices, she is consistent in proposing that structured assessment interviews are a valid and reliable way of gathering information from children who are displaying problem behaviors. Whether or not such behaviors are the outcome or symptom of the crisis event is not discussed. The school psychologist can decide under individual circumstances whether or not the interview formats available can assist in data gathering.

Assessing Family Stress

As noted earlier, McCubbin and Patterson (1981) have discussed, using a family context, problems of coping of children and adolescents. The ABCX model of family stress and coping has generated a wide array of assessment devices that can allow practitioners to document stressors and coping factors. The A-FILE was developed to assess adolescent stress. It's formal title is the Adolescent-Family Inventory of Life Events and Changes. The instrument is a 50-item self-report schedule that can record both normative (expected) and non-normative (crisis) life events and changes that an adolescence perceives. The instrument is developed to record events over the prior 12 months.

The A-FILE has been tested for reliability and validity and has more than adequate test/retest statistics. Easy to

administer, the instrument can generate information for either research purposes or to be used in counseling the adolescent. The A-FILE has been submitted to reading difficulty analysis and found to be at an advanced high school and early college-level of difficulty. As such, the instrument may be read to students who are less skilled readers . The A-FILE deals with events occurring because of transitions in the family or in growth and maturation, issues in sexuality, losses to the indiviual in the family, responsibilities and strains, substance abuse, and legal conflicts. Scoring instructions for the A-FILE are adequate. A profile of adolescent and family life changes can be developed, which shows normal limits within which many children experience the described events. Factor structure of the A-FILE has been developed and work on the instrument continues.

The A-COPE was developed to assess adolescent coping with stress. Its formal title is Adolescent Coping Orientation For Problem Experiences and was developed by Patterson and McCubbin. This instrument, although less developed in terms of statistical options, has much promise for the practicing school psychologist. Responses to the 95 items on the instrument can be used to provide information on the following patterns: (1.) Developing and maintaining a sense of competence and self-esteem. The behaviors that fall under this section refer to skills or talents of the child; (2.) Investing in family relations and fitting into the family life style. Behaviors here describe communication and actions with the family; (3.) Investing in extra-familial relationships and seeking social support. Behaviors focus on involvement with peers and community systems; (4.) Developing positive perceptions about life situations. These statements emphasize beliefs in God and comparisons between self and others in view of change; (5.) Relieving tension through diversions. Behaviors document a range of activities by which the adolescent can avoid focusing on stressors; (6.) Relieving tension through substance use or expression of anger; (7.) Avoiding confrontation and withdrawing. Behaviors listed include avoidance of people or situations that are difficult or unpleasant.

The A-FILE and the A-COPE are promising resources that allow the psychologist to gather information on an adolescent's perception of family and self. Whether or not the psychologist opts to score the responses from such instruments, the responses generated are useful facts with which the professional can weigh the adolescent's words and actions during crisis. McCubbin and Patterson also have developed other instruments that can assist

the psychologist look at families. The FILE (Family Inventory of Life Events and Changes); the FIRM (Family Inventory of Resourses from Management), the CHIP (Coping Health Inventory for Parents), the FCI (Family Coping Inventory), and the F-COPES (Family Crisis Oriented Personal Evaluation Scales) are a few of the scales available on stress and family functioning.

The authors provide additional information on what is known about families' vulnerabilities to stress and the impact of both normative and non-normative stressors on children and adolescents. To supplement these assessment tools are two volumes that would be useful references for the professional school psychologist. These volumes are part of a series, Stress and the Family, edited by McCubbin, and Figley,(1983 a, b). In these two volumes, circumstances that impart stress on a family are explored. Topics covered include family transitions, environmental demands on the family, and catastrophes that relate to illness, drug abuse, abandonment, death, unemployment, rape, and disaster.

Central to data gathering is collecting information for a purpose. Any of the instruments described above would only be administered by the school psychologist who intended to make full use of the required information. Although this seems such an obvious statement, the opposite circumstance possibly occurs too frequently. Data may be gathered for the purpose of assessing achievement or intelligence levels when such data serve no useful function in helping structure interventions. If the intent of the professional is to deliver a quick and accurate service to a child under crisis, administration of norm-referenced instruments might not be indicated. Norm-referenced tests do allow documention of changes in a child's functioning if similar data are available from a child's past. Whatever assessment strategy is employed, the psychologist needs to document, as accurately as possible, events and behaviors that have immediate relevance to assisting the child under crisis.

Documenting forces in the environment that impinge on the child may be a priority for some psychologists. Professionals with an ecological orientation already note environmental impact on a child's functioning. Behaviors shaped by environmental circumstances can be documented so that they can be modified or eliminated. Given that assessment is important for decision-making purposes, the school psychologist should opt for a strategy that gathers information relevant to the crisis events, works to confirm the accuracy and validity of such data,

and records in a child's records only data central to case management. The role of the school psychologist as case manager during crisis has been mentioned previously. Information for case managment must be the best available, involving collection of all relevant facts from child, parents, and school personnel.

As we shall see in the following cases, effective data gathering strategies were a necessity for planning during the intervention phase. While recognizing that a child under extreme crisis or stress often cannot give us the information to plan for a specific interventions, we must begin to tap all available resources to document events. Gathering information from peers, siblings, and teachers, can confirm or deny "facts" elicited to describe a particular child's crisis. At all times, the ethical standards of school psychologists are in operation.

Confidentiality during assessment is an important consideration especially when there is mandatory reporting involved. The child in crisis may be reporting events to you that must be passed on to higher authorities. Under such circumstances, confidentiality is an issue to be discussed as early as possible with the child. Clarifying the full extent of confidentiality must also be achieved with parents who could be giving you information that they would rather not have passed on to other people. If you are responsible, however, for passing on information to authorities, the ethical response is to spell this out for parents and all others giving you sensitive information.

Problems Leading to Crisis Intervention

In the following sections, school psychological services to children in crisis will be reviewed. Discussion centers on instances in which children were referred to psychologists for immediate action. Although names have been modified, the cases are real.

As you review the information, refer back to the videotape which will expand on the issues of sexual abuse,suicidal behavior, and self-abuse. The videotapes depict interactions between the psychologist and child. Missing is a depiction of involvement with parents, other than that represented by telephone contact. Clearly, parents are critical members during crisis intervention. They must be consulted before work begins, even when there is an immediate emergency that calls for your

service. Parent involvement is critical, also, for the long-term intervention plan that you or other support people develop. Consideration of crisis cases will be broken down by topic area. Sexual abuse, the first area addressed, will receive extended attention to allow for the topic's importance and demonstrate the depth to which any crisis area can be studied.

Sexual Abuse of Children (Provided by Cathy Edwards)

Sexual use of children has occurred throughout history and across many cultures. Such sexual use has alternately been regarded as normal, as immoral, criminal, or as psychopathological (Mrazek and Kempe, 1981).

Criminalization of sexual contact between adults and children is now common in Western countries. Charges against adults include contributing to the delinquecy of a minor, indecent assault, indecent acts, gross indecency, sodomy, statuatory rape, incest, and sexual abuse (Mrazek amd Kempe, 1981). Definitions of incest vary widely from country to country and state to state.

Today, adult-child sexual relations are regarded by some sectors of society as normal and natural. Child pornography is a multimillion dollar business in America and Europe. Societies exist which advocate sexual practices for adults and consenting children. Among these organizations are the International Pedophiliac Information Exchange in England and the Rene Giuon Society of California which claims a membership of 2,500 adults who have had intercourse with a child under the age of eight years (Mrazek and Kempe, 1981). However, as the general public has become increasingly aware of the extent of the sexual use of children, a strong public outcry against such practices has led to legislated prohibition of such use. In many states there are now mandatory reporting laws for physicians, educators and therapists who have reason to suspect such relations are occurring (Isaacson, 1975).

Although there is now a consensus in America that adult sexual use of children is wrong, Finkelhor (1979) criticizes a number of arguments against sex between adults and children while offering an ethical argument against such contact. Inadequate arguments include that it is intrinsically wrong both biologically and psychologically. Assertions of this type were once made about homosexuality which is no longer categorized as psychopathological. A second rejected thesis is that it causes

premature sexualization of the child. Finkelhor points out that children are curious about sex, that they engage in self stimulation and explore sexuality with each other. Finally, he rejects the contention that sexual encounters with adults are clearly damaging to children. This contention is rejected because it is based on empirical data from clinical reports of children that were harmed by such acts. However, the number of children who may engage in such acts without harm is unknown, while some individuals even claim such experiences as having been positive. Finkelhor asserts that as a society, a sexual ethic is emerging that allows any sexual act that occurs between consenting individuals; only in situations where one party does not consent is it considered illegal and taboo.

Finkelhor (1979) argues that we must never sanction sexual contact between adults and children because children are by their nature incapable of "truly consenting to sex with adults . . . because they are children, they cannot consent . . ." (p. 694). Conditions necessary for consent are that the person must know what they are consenting to and must be free to say yes or no. Children cannot give informed consent because they are ignorant about sex and sexual relationships. They are unfamiliar with not only the mechanics of sex and reproduction, but also they are unaware of the social meaning of sexuality. They are not likely to know the criteria for choosing a sexual partner, and they do not know the physical and social consequences it will have for them. Finkelhor further points out that children do not really have the freedom to say yes or no to an adult either legally or psychologically. The child is practically a psychological captive in that the adult is likely to control essential resources, such as food and in many cases is an important and loved figure. This is particularly true when the adult is a parent or parent surrogate.

Definitions

Three comprehensive definitions of sexual abuse of children are available. Simrel, Berg, and Thomas (1979) propose the following definition:

> Child sexual abuse has been defined as referring to three abuse situations. First, there is sexual assault on a child with the use of force. Second, it includes sexual contact of any kind, such as intercourse, fondling of the genitalia, exhibitionism, and sodomy,

> in which the child's participation has been obtained through bribery, coercion, or misrepresentation of moral standards. Third, it refers to sexual contact with a child when it is legally prohibited because of the age of the child or the family relationship of the abuser to the child. (p.317)

Kempe (1978) defined sexual abuse as "the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, to which they are unable to give consent, or that violate the social taboos of family roles" (p.284).

Luther and Price (1980) defined sexual abuse as "exposure of the child to sexual stimulations inappropriate for the child's age, level of psychosexual development and role in the family." Incest was defined as "sexual intercourse or acts of deviant behavior including molestation, between persons who are related, including step-children" (p. 161).

The use of the term incest has been documented since the time of Homer (Masters, 1963) but the term sexual abuse dates only from the 1970s (Kemp, 1978; Simrel et al., 1979). Not only have the terms themselves changed but the definition of any one term has varied over time making incidence, epidemiology and signs and symptoms very difficult to ascertain. In the studies that follow, definitions are given that differ from the above examples.

Incidence and Prevalance

Several authors [Jones (1982), Burgess et al. (1983), Russell (1983), Simrel et al. (1979)] have noted that the true incidence and prevalance of sexual abuse are unknown. Factors complicating gaining accurate data are lack of a uniform definition, pooling of physical and sexual abuse into the category of child abuse, sampling procedures which are retrospective, non-random and non-representative, such as studies of college freshmen enrolled in a particular class (Finkelhor, 1979), and due to serious under- reporting.

Estimates of incidence of sexual abuse of children range from 200,000 to 5,000,000 children molested each year (American Humane Society, 1972; Gagnon, 1965; Sarafino, 1979). As many as 25% of

all women in America may fall victim to a serious act of sexual aggression, exploitation, or assault before age 18 (Weber, 1977).

The National Incidence Study, which included cases known to other investigating bodies besides child protection service agencies, as well as professionals in schools, hospitals and major agencies, estimated a rate of 0.7 cases of child sexual exploitation per 1,000 children per year. The number of substantiated cases of sexual exploitation was 44,700 (National Center on Child Abuse and Neglect, 1981).

Herman (1981), reporting on five surveys of the prevalance of sexual abuse of female children since 1940, concluded that:

> The results of these five studies were remarkedly consistent. One-fifth to one-third of all women reported that they had had some sort of childhood sexual encounter with an adult male. Between four and twelve percent of all women reported a sexual experience with a relative, and one in one hundred reported a sexual experience with her father or stepfather. (p.12)

Finkelhor (1979, 1980) conducted a nonrandom survey of students, enrolled in six New England Colleges, who were mainly from white, middle and upper class populations. He found that one-fifth of the females and one-twelfth of the males had experienced some form of sexual contact with adults during childhood. Twenty-six percent of the students reported sexual experience with a relative, but only 16% of those who reported childhood sexual experiences said that the experience was with an older person.

Story and Story (1982) conducted a random-selection survey of 1,000 subjects, drawn from a pool of all 10,185 students enrolled in the spring semester of 1982 at the University of Northern Iowa. Students were asked to complete a questionnaire regarding incestuous contacts. Nine hundred seventy-six returns were received. Of these, forty-eight were refusals and one was regarded as a prank. Of those which were usable, 21.9% of the males and 20.9% of the females had experienced incest for a total of 21.4% having experienced incest. However, sibling contact was the most frequent type of contact for both males, 68%, and females, 44.6%. Fathers and stepfathers accounted for 37.8% of female and 10% of male contacts. Mothers were involved in 6% of the male contacts and 0% of the female contacts.

Many studies of the incidence and prevalance of child sexual

abuse have focused on reported cases only (DeJong, Emmett, Hervada, 1982), nonrandom college populations (Finkelhor, 1979), or randomized college populations of incestuous cases (Story & Story, 1982). Russell (1983) conducted a randomized study of 930 adult women in San Francisco in order to provide a sounder basis for the estimate of the prevalance of interfamilial and extra familial sexual abuse of female children. A probability sample of households was drawn by Field Research Associates, a public opinion polling organization. Interviewers were trained and detailed interviews were conducted. Respondents were told that the survey would question their experiences of extra and intrafamiliar sexual abuse.

> Extrafamiliar child sexual abuse was defined as one or more unwanted sexual experiences with persons unrelated by blood or marriage, ranging from petting (touching of breasts or genitals or attempts at such touching) to rape, before the victim turned 14 years, and completed or attempted rape experiences from the ages of 14 to 17 years (inclusive). . . Intrafamiliar child abuse was defined as any kind of exploitative sexual contact that occurred between relatives no matter how distant the relationship, before the victim turned 18 years of age. (p.135)

After the purpose of the survey was explained, 36% of the sample refused to participate. Of the 930 women, 16% reported at least one experience of intrafamilial sexual abuse before the age of 18 years. Thirty-one percent had experienced at least one incident of sexual abuse by a nonrelative before the age of 18 years. When both categories were combined, 38% of the 930 women reported sexual abuse before the age of 18 years, and 28% before 14 years. Of the total cases of child sexual abuse, only 2% of intrafamilial and 6% of extrafamilial were ever reported to police. Russell concluded that "these extremely low figures provide powerful evidence that reported cases are only the very tip of the iceberg" (p. 142).

Epidemiological Factors

In a retrospective study of 566 children ranging in age 6 months to 16 years who came to the Pediatric Sexual Assault Center of Thomas Jefferson University Hospital in Philadelphia, Dejong, Hervada and Emmett (1983) identified the following

epidemiological factors. Females accounted for 81.8% of the cases and males accounted for 18%. The racial distribution was 74.1% black, 19.6% white, 5.5% Spanish surname, and 0.2% Oriental. Child victims came from all over the city which has a predominantly white population, 58%, and a 40% black population.

Age distribution varied with both sex and race. Females were distributed bimodally with peaks at age 6 years and 15 years. Males peaked at 7 years. Children's parents were the most frequent initiators of evaluations, 51%. Physicians had referred one-tenth of these parents. Other referral sources included: police, 22%; related adults, 5%; unrelated adults, 3%; social service agencies, 2%; and self-referral, 2%. The assailants were male with the exception of 4 females, 3 of whom had male accomplices. Twenty-nine percent of the assailants were acquaintances (37%). Most victims has been assualted anally, 28%, or vaginally, 48%. Evidence of trauma was found in 25% of the cases with only 1.5% considered to have psychological trauma.

The study concluded that:

> Reporting the use of violence, evidence of physical trauma, perineal trauma, and the total evidence of trauma increases with decreasing degree of familiarity between victim and assailant. The occurrence of the assault in the child's home or the assailant's home, the reporting of multiple episodes of assault before presentation, and the delay before reporting increase with increasing degree of familiarity. (p. 159)

In a Canadian study (Grant, 1983), similar findings were made. Assailants were known to the child 70% of the time, with 45% being related and 25% acquaintances. Victims were primarily female, 86%, with 14% being male. Vaginal assault occurred in 45% while anal assault occurred in only 10% of the cases [About half the rate found in the Philadelphia study] (Dejong et al., 1983).

In an analysis of data collected from the Georgia State Central Registry of reported sexual and physical abuse from July 1975 through December 1979 (Jason, Williams, Burton, & Rochet, 1982) the following was found. Ninety-one percent of children confirmed as sexually abused were female; there was no difference between races. Males who were sexually abused tended to be younger than females; 16% of the children who were younger than 8

years were male even though males comprised only 9% of the total number of sexually abused children. Age-specific data indicated that the incidence rose after age 2 years with only a slight peak at pubertal ages. The assailants were 98% male and only 11% were unknown or unrelated to the child, 54% were the natural father, 34% the stepfather, 2% were adoptive fathers and 4% were father substitutes. Poor rural white children, living with their mother as the only head of the household, were at a risk five times that of the base rate for the general population. Poor rural black children, with the mother as the single head of the household, were at a risk 1.5 times that of the base rate. Physical injury was present in only 19% of substantiated sexual abuse cases. The overall confirmation rate for reported sexual abuse was 62%; however, the rate was higher for clinical referral sources, 73%, and for law enforcement sources, 75%. The concerned citizen or relative had the lowest confirmation rates.

Associated Features of Risk

DeFrancis (1969) reported that parental inadequacy was strongly related to sexual victimization of lower class urban child victims. He found a large number of child victims came from homes characterized by parents with personal and social problems, such as alcoholism, physical or mental handicaps, mental retardation, insufficient education, or illiteracy. In addition, a number of victims were from broken homes or from families in which the father or mother was not the natural parent. Since there was no comparision group, it cannot be determined if these factors represent risk determinants or whether they are simply typical characteristics associated with the environment of lower class urban youth.

Finkelhor (1980), in comparing female victims of childhood sexual abuse to nonvictims, found that victims were more likely to come from families with incomes less than $10,000, to have grown up on a farm, to have come from families marked by marital strife, and to have grown up with one or both natural parents absent from the home. Victims were also more likely to have had a stepfather or stepmother and more likely to have been emotionally distant from their mothers and/or fathers. It should be noted that these groups were drawn from college populations in New England.

Story and Story (1982) found a significant correlation ($p < .001$) for three factors: (a) overcrowding in housing, (b) a socially isolated family with few friends, and (c) feelings of

being somehow deprived as a child, when comparing a random sample of college incest victims with their nonvictimized peers.

Gruber and Jones (1983) studied a sample of female adolescents from a rural, predominantly white, low to lower middle class population of Western North Carolina. Two groups were drawn from a community-based treatment program for delinquents with histories of chronic behavior problems such as truancy, running away, misconduct in school or at home, drug use or other first offense crimes against property. The two groups were matched for age at the time of admission to the treatment program or age at which sexual victimization occurred. Twenty victims of rape, attempted rape or acts of forced intimacy were identified as were 21 nonvictims. Fourteen social risk factors were assessed through the use of a structured personal interview in a questionnaire format. Analysis of data revealed that none of the variables related to deviant behavior on the part of significant others discriminated between victim and nonvictim groups. The personal behavior patterns of the adolescents, such as age of first date, were likewise nondiscriminant. However, two characteristics of parental environment were significantly related to the victim group. The victims were less likely to be living with their natural parents and more likely to live in homes marked by marital strife. The authors conceded that their sample was small and not representative of all adolescents, thereby limiting the generalizability of their findings. However, the authors called for more studies comparing both victims and nonvictims in order to ascertain what factors increase vulnerability and what factors contributed to reduce susceptibility.

Signs and Symptoms

The studies cited clearly illustrate that cases of sexual abuse of children are grossly under-reported and that a significant number of children are sexually abused each year. Since such acts are illegal and many states have mandatory reporting laws, how are these reporters to identify such sexually abused children? For the physician, this task is simplified somewhat by his or her access to physical findings. Sgroi (Burgess, Groth, Holstrom, & Sgroi, 1983) suggests that the following information, if present, is indicative of sexual assault:

1. Sperm recovered from the vagina or genital/rectal region of a female child.

2. Pregnancy
3. Genital or rectal trauma in children of both sexes
4. Gonorrhea infection of the vagina in female children or the pharynx, urethra, and/or rectum in children of both sexes.
5. Foreign bodies in the vagina of female children or in the urethra or rectum of children of both sexes
6. Statement of sexual assault by the target child
7. Corroborating statements of sexual assault by others (these could be other children, including siblings)
8. Confession by the perpetrator
9. Other evidence of trauma that supports the child's statement (e.g., bruises elsewhere on the body if the child described being beaten; marks at the wrists and ankles if the child was allegedly tied up, etc.)
10. Supporting material evidence (e.g., blood or semen stains on the clothing) (p.145)

Sgroi (Burgess et al., 1983) goes on to state that "the existence of carefully documented supporting evidence that child sexual assault did, in fact, take place may constitute the most significant, therapeutic leverage in working with a family . . . especially . . . if a parent or parent-figure is the suspected perpetrator" (p. 145).

For the nonphysician who is a mandatory reporter, the task of identifying sexually abused children is very difficult and subject to false identification due to the fact that there is no nonphysical pathognomonic indicator and to the fact that many of the signs and symptoms may be associated with other physical or psychosocial conditions. For example, the following are listed as possible covert symptoms and signs of sexual abuse (Husain & Ahmad, 1982): somatic symptoms without obvious organic cause, school difficulties, poor peer relations, symptoms of emotional turmoil, sleep difficulties, and nightmares or phobias particularly when they represent a regression from better functioning. Jones (1982) suggests that forced sexual activity often produces fear states, night terrors, clinging behavior and developmental regression in children under five years of age. Anxiety, depression, insomnia, conversion hysteria, massive weight loss or gain, school failure or running away from home can be manifested in sexually abused school-age children. Pasco (1979) states that preschool children may demonstrate failure to thrive, exaggerated clinging behavior, sleep disturbances, enuresis, encopresis, and thumb sucking in response to sexual

abuse. Pre-teens of school age may exhibit school failure, changes in appetite, fear or anxiety states, depressive symptoms, conversion or hysteria symptoms, phobias, and tics. Sexually abused adolescents may exhibit personality changes, antisocial behavior, promiscuity, depression, psychosomatic preoccupations or complaints, drug abuse and runaway behavior,

Gross (1979) reports four cases of incestuous rape that were followed by the development of hysterical seizures. In two of the cases, the adolescent patients had spells of absence which lasted from a few minutes to a few hours and two had convulsions associated with these absences. The two with convulsions had been on anticonvulsive medication without response. All four patients were eventually referred for psychiatric evaluation. Three of the four had made serious suicide attempts before admission. One had serious suicidal ideation. One had tried to run away from home prior to slashing her wrists. All four had alcoholic fathers or father figures who had repeatedly raped them at a pubertal age.

Goodwin et al (1979) reports six cases of hysterical seizures associated with incestuous relationships. All six females experienced relief from seizures when psychotherapy began to explore the incest experience. All six had run away from home; all had threatened or attempted suicide. Four were promiscuous. Individually the patients met unspecified diagnostic criteria for (a) conversion disorder with hysterical seizures, (b) hysteria, (c) depressive neurosis with hysterical seizures, (d) latent schizophrenia, (e) personality disorder with hysterical seizures, and (f) mixed character disorder with depression.

When Burgess et al (1984) studied 66 children and adolescents exploited by 14 adults in 11 sex rings, three-fourths of the victims demonstrated patterns of negative psychological and social adjustment after the rings were exposed. Sixty-one percent of the victims had been ring members for more than a year and more than half the victims had been used in pornographic photographs. Forty-nine of the children were males and 17 were females. Their age at the time of discovery ranged from 6 to 16 years and 32% of the children were related by blood. The adult ring leaders were all male. The sexual acts included mutual masturbation, oral and anal sex, sadism, exhibitionism, degradation, and humiliation (urinating into the mouths and onto the faces of others). Burgess et al (1983) identified four types of stress-response patterns: (a) integration of the event, (b) avoidance of the event, (c) repetition of symptoms, and (d)

identification with the exploiter. These response patterns are described in detail:

> Integration of the event. In this response pattern, the child has mastered the anxiety about the exploitation. When asked about the event the child neither avoids nor encourages discussion but is able to talk about the event with reasonable objectivity. The child believes the adult was not only wrong but was responsible for initiating the behavior. Criminal prosecution of the adult is viewed positively. The child had a future orientation, re-establishes friendships with a new peer group, and shows evidence of making age-appropriate adjustments with peers, family, and school. (p. 658)

> Avoidance of the event. In this pattern of response, the anxiety about exploitation remains sealed off either consciously or unconsciously. When asked about the event the child denies and refuses to recognize that the event occurred and may not be able to give a clear picture of it. The child often has a stoic demeanor and actively avoids discussion. The child is still afraid of the offender and tends to have a present orientation. So long as the child is not under stress, life is managed as if nothing has happened. Stress and a breakdown of avoidance patterns may bring forth symptoms reminiscent of the reactions at the time of the disclosure; sometimes depression and self-destructive behaviors appear. Relationships with peers may well have been terminated, family relationships are strained, school difficulties may persist, and minor antisocial acts many surface. The child does not have a sense of right and wrong and believes that other children are not exploited. Thus, the child refuses to talk about the event. Unconsciously the child feels responsible, feels badly, and even feels that he has injured himself and his family. (p. 658-659)

> Repetition of symptoms. In this response pattern the acute posttraumatic stress disorder becomes chronic. The symptoms may be related to the event or they may be a compound reaction to previous victimization of other traumatic events. The child's role and anxiety over being powerless are increased and the child is unable to master or exert control over anxiety generated. When

asked about the event, the child with recurrent symptoms becomes quite anxious. He feels guilty and blames himself. The child is not in control of his thoughts about the event; the event is still operant and conscious. Family relationships are often unstable, peer relationships may not be reestablished, and the child is not successful in socializing with children of the same age and may associate with younger children. The child may drop out of school, continue sexually explicit behaviors, or be repeatedly victimized. The child believes he is to blame, that he should have known better, and that he should have told his parents. The child is oriented to the past and may be hopeless about the future, believing that it is not possible to make up for what has happened. (p. 659)

Identification with the exploiter. In this response pattern the child has introjected some characteristic of the anxiety caused by the exploitation and assimilates the anxiety through impersonating the aggressor. The child transforms himself from the person threatened into the person who makes the threat. The child masters the anxiety by exploiting others and adopting an antisocial position toward peers, school, and family. The child who identifies with the exploiter minimizes the exploitation and pornography, resents the interference of the authorities . . . . The child maintains emotional, social economic ties with the offender and feels sorry or angry that the adult is exposed and convicted. The problem and "hassle" are seen as caused by the authorities and intervenors. The child has difficulties with authorities, especially in school, and often drops out after disclosure. Use of drugs and alcohol, which was part of the ring ritual, continues and increases. There is a shift in the child's belief system that supports antisocial behavior. The child is oriented only to the present. (p. 659)

Burgess et al (1983) go on to report that responses to open-ended questions asked of children and parents about general symptoms prior to disclosure included reports of genital complaints, headaches, loss of appetite, stomach aches, short vomiting spells, difficulty sleeping, marked daydreaming and fantasizing, sudden changes in school behavior, declining grades, withdrawal from peer activites, arguing with siblings, parents and peers, acting out behaviors such as stealing, setting fires,

and using sexually focused language, dress and mannerisms.

After disclosure, 45 children reported reexperiencing the events through intrusive thoughts, flashbacks, dreams and night terrors. Forty-one children experienced withdrawal from others and the environment. Forty-nine experienced new symptoms of antonomic arousal, fighting, risk-taking behaviors and uncontrollable temper outbursts. Many somatic complaints surfaced as did bedwetting and general malaise. Sleep disturbance, emotional lability, irritability and crying spells were common.

Many behaviors and symptoms are associated with children who have been physically abused and many occur in other physical or psychosocial conditions. Table 4 presents patterns of stress response involving children in one study.

The diversity of signs, symptoms, and diagnosis of children who have been sexually abused is well described in a study (Adam-Tucker, 1982) of 28 sexually abused children referred to a university-based child guidance clinic during 1978. These 28 children comprised 2.7% of all 1,037 children referred during that year. These children were divided into three groups. Group 1 consisted of children referred explicitly for sexual abuse without previously reported signs of distress. Group 2 children were referred for both sexual abuse and because they were symptomatic. Group 3 were children who were referred for psychiatric evaluation because of symptoms alone with the sexual abuse discovered during the evaluation. Data were gathered from clinical records on such variables as presenting complaints, diagnosis, age, gender, race, reason for referral, and severity of behavior problems as reported by parents on the Louisville Behavior Check List. The characteristics of the three groups are presented in Table 5.

The findings of this study (Adams-Tucker, 1982) were that children molested by their fathers appeared to suffer more independent of their diagnosis. These children evidenced significant depression and/or withdrawal. The severity range for behavior was moderate to extreme; half of these children required inpatient care. One child who was molested by both her father and mother was the most severly distressed to the point of psychosis. Many of the chilren needed psychiatric care, even those who had been abused only once. The nine children who were involved in intercourse showed the most emotional illness. Children who were first molested at age 6 or 7 had the most

Table 4

Patterns of Stress Response of 62 Children Exploited in Sex Rings

(by Sex, Participation in Pornography, and Length of Time in Ring)

Characteristic	Integration of Event	Avoidance of Event	Repetition of Symptoms	Identification With Exploiter
Sex[a]				
Male	13	13	8	11
Female	3	4	8	2
Participation in pornography[b]				
Yes	6	7	9	12
No	10	10	7	1
Time in ring[c]				
Less than 1 year	10	11	3	0
More than 1 year	6	6	13	13

[a]X2 = 3.09, df = 3, p = .20.
[b]X2 = 7.28, df = 3, p = .06.
[c]X2 =11.31, df = 3, p = .01.

Table 5

Characteristics of Three Groups of Sex-Abused Children.

Characteristics	Group 1 (N-12): Sex Abuse With Unexpected Symptoms[a]	Group 2 (N-11): Sex Abuse Plus Symptoms[b]	Group 3 (N-5): Symptoms With Unexpected Sex Abuse[c]
Chief complaint			
Sleep-related	4	1	0
Psychosomatic	3	1	0
Anxiety	3	4	0
Oppositional	3	3	1
School-related	1	1	2
Sex-related	1	3	0
Running away	1	2	0
Aggression	0	0	2
Withdrawal	4	2	2
Suicide	0	4	2
Diagnosis			
Adjustment reaction	5	2	0
Behavior reaction	6	6	4
Neurosis	0	3	0
Psychosis	0	0	1
Incomplete evaluation	1	0	0
Louisville Behavior Check list Severity level[d]			
No pathology	1	0	0
Mild	4	1	0
Moderate	4	2	0
Severe	0	2	2
Extreme	1	2	2
Actions taken after Learning of sex abuse[e]			
Supportive	5	2	0
Minimally supportive	1	1	0
Unsupportive	5	8	4

[a]These 10 girls and 2 boys had a mean age at evaluation of 7.7 years (range, 3 years 8 months-14 years 11 months). They had been abused

for a mean of 2.3 years and their mean age when first molested was 6.3 years (range, 3-13 years).

[b]These 8 girls and 3 boys had a mean age at evaluation of 9.9 years (range, 2 years 6 months-15 years 7 months). They had been abused for a mean of 2.3 years and their mean age when first molested was 7.9 years (range 2 years-15 years 8 months).

[c]These 4 girls and 1 boy whose mean age at evaluation was 11.8 years (range 4 years 9 months-14 years 3 months). Had been abused for a mean of 6 years and their mean age when first molested was 7.8 years (range, 3 years 6 months-13 years 6 months).

[d]Group 1 had a mean score of 45, group 2, 56, and group 3, 67. Data were not available for 2 children in group 1, 4 in group 2, and 1 child in group 3.

[e]Data were not available for 1 child in groups 1 and 3.

severe diagnosis, depressive neuroses, behavior disorders and one case of psychosis. Children first molested at age 7 1/2 had more moderate behavior reactions, such as anxiety, withdrawal and some elements of depression. Children first molested at 10-15 1/2 years of age were depressed, withdrawn, and prone to aggression against self.

The 28 children together exhibited a wide array of problems. These problems were self-destuctive/suicidal behavior, withdrawal, hallucinations, aggression, sex-related complaints, running away, school difficulties, oppositional behavior toward others, anxiety, psychosomatic complaints, and sleep-related complaints. Many very young children required hospitalization because of debilitating panic that affected their functioning at school, with siblings, parents and peers, and because of disturbances in sleep and body functions.

Adams-Tucker (1982) concluded by stating:

> "Very young children should be asked specifically about sexual abuse whenever they have complaints or present behavioral evidence of a psychosomatic, sleep-related, anxious or sexual nature. Older youngsters should be asked about sexual abuse whenever withdrawal, runaway, and suicidal behaviors are the presenting difficulties. . . In short, the problems suffered by these children are as serious as those of children seeking psychiatric help for any reason. All clinicians who work with children should inquire more frequently about sexual molestation. . . . Suffering occurs with only a single episode of sexual victimization.
>
> Child mental health professionals would do well to (1) improve their identification skills for cases of sexual abuse among young female children, in particular, and (2) help nonmolesting parents to be energetically supportive and more strictly child centered when their molested child steps forward to name his or her molester. (p. 1256)"

Other indicators of sexual abuse in children are children's drawings (Burgess, McClausland, & Wolbert, 1981). Acute rape trauma syndrome in its disorganized phase may be indicated when a child's drawings show a marked shift from age-appropriate figures to disorganized objects that require interpretation by

the child. By contrast, in ongoing sexual victimization where the child is pressured by an authority figure, the child's drawings may indicate sexual activity. Suspicions should be raised where drawings show repeated stylized figures, according to the authors (1982). DiLeo (cited in Burgess et al., 1982) has noted that it is quite rare for children to attempt to represent genitalia in their drawing; thus, neglect of genitalia was noted in a majority of children from diverse cultures.

Psychometric Signs of Sexual Abuse

King and others (1983) states that "there have been no studies involving standardized psychological assessment of the effects of sexual abuse of children and adolescents" (p. 12). A review of the literature confirms this observation. King (1983) presented to the 1983 APA Annual Meeting preliminary data from the evaluations of 14 girls, drawn from a sample of adolescents seen at a Pediatric Emergency Clinic for the treatment of sexual abuse. There was no comparison groups of non-sexual abused females.

The evaluation battery included the Peabody Picture Vocabulary Test, Piers-Harris Self Esteem Inventory, Interpersonal Trust Scale, and Rorschach Ink Blot Test. Means from the sample were compared to national norms. Mean scores for the children's Interpersonal Trust Scale and the Piers-Harris Self Esteem Inventory were not significantly different from the national norms, although eight of the girls had pathological scores on the Piers-Harris. No score on the Child Behavior Check List fell at or above a t-score of 70, but most scores fell above a t-score of 60 (one standard deviation above the mean). The highest score was a 69 t-score on Factor II, the somatic complaint factor

On the projective test, the Rorschach gave significant results that were both clinically relevant and statistically significant. The Rorschach was administered, scored, and interpreted using Exner's comprehensive systems. Only t-scores that were significant at the .001 level were reported. The ZD score for these subjects was -5.2, indicating that they were negligent in scanning a stimulus field thus reducing cognitive efficiency. Such individuals are likely to reach decisions impulsively without adequate understanding of environmental factors and thus may get into behavioral difficulties.

Perceptual accuracy for these subjects was below national norms as evidenced by F+ and X+, t-scores of .64 and .60 respectively. Scores of .70 and below are considered impaired. King (1983) interprets this to mean that these sexually abused girls have idiosyncratic or unusual perceptions of reality.

This sample also had lambda (L) ratio scores of 1.70 versus the national norm of .73. Such high scores are a function of cognitive simplification and result from ignoring aspects of the ink blots such as movement, color or shading, and focusing on form.

These subjects were also significantly high in little-m (inanimate movement) and y (shading) which are indicators of emotional distress. They were significantly low on the affective ratio (Afr), indicating an unwillingness to confront emotional issues. This group also scored significantly higher on two measures indicating cognitive slippage. These were deviant verbalizations (DV), which is scored when unusual or odd speech is used, and incongruous combinations (INCOM), which is scored where there is an incongruous condensation of blot images into one percept such as "blue snow."

These preliminary findings are not generalizable due to such limitations as a lack of control and a very small number of subjects. However, this report is a needed step in the investigation of the psychometric characteristics of sexually abused children.

Conclusions

Sexual abuse of children appears to be an ominously frequent occurrence which is drastically under-reported. This practice is ethically indefensible and is often associated with emotional, behavioral, and physical damage or dysfunction. Because of this, the sexual abuse of children is criminalized. A number of professional disciplines which come frequently in contact with children are designated mandatory reporters. As Sgroi (1975) states:

> . . .it behooves every professional who deals with children to be aware that sexual molestation exists, to recognize danger signals--especially in high risk children--and to be knowledgeable about his ot her state's reporting laws and sources of help. Sexual abuse is certainly not the problem of any single

> profession or segment of society. A strong united front is required to push back the last frontier in child sexual abuse and assist the sexually molested child. (p. 21)

Unfortunately, this task is immensely complicated, particularly the farther removed one is from physical findings, as there are no pathognomonic behavioral or emotional indicators of sexual abuse. Great caution is warranted in advocating for children in that they are also entitled to protection from invasive inquiries which can be potentially as coercive and damaging to the child and family as sexual abuse itself. Investigative procedures by social and law enforcement agencies are not benign proceedings.

Additional caution is also called for in so-called "preventive" programs which seek to educate the child to the danger and impropriety of sexual contact. Children also have a right to experience the love and non-sexual physical affection of their family and friends and to have a childhood not overly encumbered by the terror of what <u>might</u> be.

The general public in Iowa is very conscious of the issue of sexual abuse. For that reason, this handbook has given extended attention to the issue of sexual abuse. The care given to the study of abuse coincides not only with the importance of the topic for the general public but with the demand for psychological services that generally follow traumatic events involving sexual abuse and physical abuse. The broader notion of child abuse elicits similar reactions from the public. The care that the psychologist can provide to a child and a family may involve intervening in a crisis situation. Long-term intervention may be beyond the role of the school psychologist, as courts and protective agencies bring in an array of other mental health and juvenile authorities.

The general strategy of providing emotional release, data gathering to ascertain relevant information, and working with the child and family to elicit a contract for change will be followed during many cases of child or sexual abuse. The videotape example of one case involving sexual abuse provides an illustration of the functional value of school psychological services provided at a time of crisis.

Given the weight of the attention to child and sexual abuse issues, the school psychologist should be aware of all resources

in the school or community focused on child abuse. In Appendix A, a brief handout on incest elaborates on one segment of the abuse theme.

Runaways

Children facing physical or psychological abuse or rebelling against structure in the home may consider leaving the home environment to live elsewhere. Nonapproved leaving can coincide with problems with juvenile authorities. In communities with a structured program of juvenile supervision, the students can come in contact with programs for status offenders, children considered to be in trouble with authorities while committing actions that would not warrant similar interventions if they had been adults. In an earlier section of the handbook, the issue of running away was raised as being tied to economic and social considerations. Children who have run away or are considering it may be willing to provide information to at least one adult in a position to assist them.

School, courts, mental health facilities, and probation programs are traditional sources of information about runaways. Records mantained by schools for attendance purposes or to note discipline actions can assist the psychologist to document a child's current status. The notion of running away qualifying as a crisis may only be true under limited circumstances. Parents and school authorities may not even be aware that the absence of the student qualifies as running away. If running away is not labeled as a crisis by parents, the child, or school authorities, support services may not be requested. When running away is seen as sufficient to elicit a crisis intervention response, the school psychologist is in a position to review existing information on the child's school attendance, participation in school and juvenile programs, and to review with the parents plans to change relations with their child. While this section will not elaborate on response options to dealing with runaways, school psycholgists should be familiar with community programs available to support a child's school attendance and living arrangements. The crisis response of emotional ventilation, information gathering and contracting for change has been validated with children who are runaways.

Suicide or Suicide Threats

The child threatening suicide or having made an attempt will generally elicit immediate attention from mental health professionals in the school and community. Mandatory reporting of such actions is found in almost every location. The school psychologist requested to deal with the problem of suicide will be expected to provide immediate attention that generates collaboration between the parent, child, and support persons in the school and community. Accurate data gathering from the child and parents is critical to the plan of action involving immediate and long-term care. The videotape has provided an example of a situation in which a young adolescent has considered suicide. The school psychologist emphasized data gathering and parent involvement before generating a plan of action.

In the section below, a case study of a different student is described. The events again are real and represent a past intervention from a school psychologist in Iowa.

BACKGROUND (Case provided by Linda Aubey)

Sarah is a 16 year old female currently enrolled in the 10th grade in a suburban school district. Sarah lives at home with her natural mother and stepfather. Both parents work outside the home and usually are not home at the same time when Sarah is present; thus discipline is somewhat inconsistent, although the primary responsibility for discipline is left to the father. Two younger siblings are at home also.

Sarah has a fairly good academic record to the point of difficulty that is described below. Her CAT scores were above 118 in all areas in the 5th grade. Although her grades have been above average, Sarah says that she feels "dumb" and has problems learning. She thinks that her skill levels are well below those previously obtained and her work is sometimes not acceptable to her teachers. This appears, however, to be primarily due to her lack of effort and fear of failure in attempting things she assumes she cannot do.

INITIAL PRESENTATION OF THE PROBLEM

Sarah was referred to the school psychologist on an emergency basis after confiding to her guidance counselor that she was contemplating suicide. The guidance counselor came into the psychologist's office with the student to receive assistance and to assure accuracy of information-gathering. At this time the guidance counselor also expressed to the student that he felt it would be better if she talk would to the school psychologist about the problem.

(Note: Throughout all steps involving any "action" taking place, such as calling parents, and involving other personnel, etc., the student was always informed of this intent first and verbal agreement to proceed was obtained.)

The problems expressed to the psychologist by the student included saying she "didn't want to live anymore" and her "life was a mess." Sarah also commented on fights that she had at home with her mother, problems with her current boyfriend, fear of losing or not having friends, and feelings that she didn't belong in her home. She expressed a desire to be killed in an accident so she'd be "out of the way." She expressed guilt, however, about causing her family more pain. She was unable at this point to spontaneously identify anything positive in her present life situation.

Physical symptoms that were present included uncontrollable shaking and crying, extreme anxiety expressed by inability to sit quietly, and reports of an upset stomach and headache.

INITIAL CASE DISPOSITION

The immediate problem of wishing to be dead was discussed, including determination of how Sarah planned to kill herself and if those means were available to her. At this point, Sarah appeared to become hesitant and although she said that she had planned how she would kill herself, she wasn't really sure that she could do so, She agreed that she needed further counseling, and that the psychologist could contact her mother.

The psychologist called the mother at work and discussed the situation with her. The psychologist recommended that an outside agency therapist be contacted to further assess the case and the mother readily agreed to do so. Sarah's mother made an

appointment for later on that afternoon and then came to school to pick Sarah up and take her to her appointment. (During the time Sarah was waiting, she was allowed to stay in the office area and rest, both because she was feeling ill and also to allow staff to watch her.)

After the initial session at the Mental Health Center, that therapist was contacted (after 2-way releases were obtained from Sarah's mother). The therapist thought that a suicide attempt, though possible, was not imminent and it was jointly agreed by the therapist and the school psychologist that Sarah could return to school with a brief daily or every other day check in with the school psychologist and bi-weekly sessions with the therapist at the Mental Health Center. These recommendations were discussed with Sarah and her mother by the therapist and agreement was reached. Additional telephone contact was initiated by the mother with the school psychologist and the mother was encouraged to call whenever she wished.

(Note: Throughout the case, the building principal was kept informed of the situation on an as-needed basis. Minimal if any information, however, was shared with the classroom teachers as a result of specific requests made by the mother and student.)

CASE TREATMENT

Sarah was seen 3 to 4 times per week by the psychologist. Frequent contact over the phone was made with her therapist and this contact was discussed with Sarah. Counseling was in the school setting and primarily focused on relaxation training and discussions of frustrations and difficulties Sarah was experiencing in school. Many of these discussions focused on other difficulties as well. Additional treatment techniques used included working with Sarah to help her make more positive "I" statements and to focus on the positive aspects of her life, as well as to establish some attainable short-term goals. Sarah's affect changed frequently and, in general, she found it difficult to deal with any minor problems that she faced. Her anxiety and depression continued although appeared less acute.

FINAL DISPOSITION

Two weeks after the initiation of treatment, Sarah was sent to the psychologist's office in an extremely agitated state, similar to that of the initial contact. Her verbal descriptions of her suicide thoughts were more direct, including more emphasis on completion such as "Being dead is just easier." and "I can't be like this anymore, I'm so depressed, etc."

At this point, the school social worker was contacted. He subsequently talked briefly with the student and then after some discussion with the psychologist and guidance counselor, it was determined that the school social worker would contact the mother and inform her of the situation. While this occurred, the psychologist did some relaxation training exercises with the student to help her to relax. Physical symptoms were reduced, but her verbalizations remained the same.

After extensive discussion with school personnel, Sarah's mother, her therapist, as well as Sarah herself, it was decided that hospitalization was necessary to deal with the immediate suicide threats and to reduce the anxiety. The social worker took Sarah to the hospital and met her mother there. She was admitted and spent two weeks in that setting.

FOLLOW-UP

After Sarah's return from the hospital, follow-up was done in much the same manner as before hospitalization, with continued communication between psychologist, therapist, and social worker. As a result of medication, Sarah was able to respond to treatment more successfully as her anxiety and depression were greatly reduced. Three to four weeks later, medication was dropped and continued improvements were seen.

Key points involved in this crisis intervention:

1. Keep everyone that "Needs to know" well informed; this saves time later if decisions must be made quickly.
2. Be sure that you have some history and some information on the student as this also can save

time. It is important that you be able to accurately see the student's situation as they may not be able to.

3. Involve the school social worker to help coordinate outside agency and parent efforts and communication as well as help in making decisions.

Dealing with suicide or a child threatening to hurt himself or herself is a responsibility representing extreme challenge to the school psychologist. Again, as in the case of sexual and child abuse, the general public is very aware of the problem of suicide among children and has devoted increased attention to developing programs to help children. With the weight of such attention on support service providers, the professional school psychologist should be aware of community agencies which specialize in suicide prevention. Many communities across Iowa have developed special programs to educate children about pressures in general life that can lead to thoughts of suicide. Prevention programs to alert children and parents to stresses of ongoing life represent one component of a total psychological program that can be directed towards the issue of suicide.

Psychosomatic Complaints (A case study provided by John Hartson)

Many times the events that bring a child to the attention of a psychologist are complex in terms of their origins. The child not attending school may be influenced by any of the number of factors, including emotional difficulties coping with any aspect of home or school environments. The following case study describes one situation in which absence from school coincided with complaints of abdominal pain. The intervention by the school psychologist was effective in eliciting information about correlates of the physical responses of the child to events surrounding her.

Nancy, a 13 year old female, was referred to the school psychologist by her school nurse and junior high guidance counselor. During the previous four weeks, Nancy had complained of recurring abdominal pain and had reported to the nurse's office on a daily basis during the first two weeks. She had subsequently missed the last two weeks of school. During that period, she had been seen at a local hospital and a complete gastrointestinal (GI) evaluation had proven negative. According to the nurse and guidance counselor, Nancy would be returning to

school the next day and they requested the services of the school psychologist in facilitating her return. The school psychologist requested that Nancy's mother (Mrs. R) accompany her to school so background information could be obtained.

History

Nancy's parents had separated when she was 5 years old. Nancy spoke to her father frequently on the telephone and they regularly corresponded. Her relationship with her father was described as good. Following her parents' divorce, Nancy and her mother moved in with Nancy's widowed maternal grandfather. During her elementary years (ages 6-11) Nancy and her mother continued to reside with the grandfather. During that time, Mrs. R was employed as a legal secretary which often necessitated longer working hours. The grandfather had assumed the role of the primary caretaker during the after-school to early evening hours and on occasional weekends. According to Mrs. R, Nancy had developed a very strong attachment to her grandfather. During those years, Nancy was described as a happy child who had a number of friends and did very well at school.

Following Nancy's 5th grade year, her mother decided to enroll at a university to complete her B.A. degree. Mrs. R resigned her position and the family moved.

Nancy entered the 6th grade the following month. She was described as being unhappy during the 6th grade. During the first several months, she frequently asked if they could return to her grandfather's home. She complained frequently that the children in her class were "immature" and she made very few friends. Her closest friend at school was a 4th grade girl. Despite her complaints about the other students and the school in general, Nancy maintained excellent grades during the 6th grade.

Nancy began experiencing abdominal pain during the second semester of 6th grade. She and her mother were not greatly concerned with the stomach pains and when the frequency of the complaints decreased during the summer, they received even less attention. During the summer, however, Nancy had a severe stomachache and discovered that she was able to provide some reduction in the pain through self-induced vomiting. She did not tell her mother of this practice, but continued to use the vomiting for relief of pain with greater frequency during the remainder of the summer and through the first nine weeks of 7th

grade.

During the second quarter, the frequency of the abdominal pain increased to two to three times per week. Self-induced vomiting occurred at a frequency of about once per week. A week prior to semester exams, the frequency again increased (four to five times per week) with self-induced vomiting occurring two to three times per week. At the point in time, Nancy remained at home and subsequently missed final exam week and the following week. It was at this point that her mother sought medical advice.

Interview

During the school psychologist's initial interview with Mrs. R, she related that the family had major financial difficulties. Despite working on a part-time secretarial job and receiving ADC payments, there was little money available for other than necessities. Mrs. R felt she was under a great deal of stress. She had lost the ongoing emotional and financial support of Nancy's grandfather as well as other support systems. Mrs. R was not doing well in school, she had few friends, few opportunities for relaxation, and Nancy's recurring illness was adding to her perceived level of stress.

Nancy presented for the interview as a tall, attractive 13 year old. The school psychologist was immediately impressed with Nancy's style of clothing which appeared "grown up." She remained spontaneously verbal throughout the interview session and appeared to be working diligently at maintaining a "young sophisticate" image. Nancy admitted to little worry and did not recognize or readily admit to any particular stressors in her life. As the interview progressed, there were notable shifts between her attempts to act like an adult and act like a young adolescent. Nancy commented that she and her mother were best friends and that they shared all their concerns with one another and were more like roommates than mother and daughter. She vascilated between appearing cool, reserved, and very articulate to dependent, silly, and confused. Nancy's responses to a sentence completion task were very similar to her overt behavior and varied between adult-like and age-appropriate responses. When questioned about her former 6th grade classmates, whom she had previously described as immature, Nancy said, "that they played

and laughed too much and did not take things seriously." She then proceeded to tell the school psychologist that one of her favorite extra-curricular activities was going to her Girl Scout meeting where she could play tag and play games with the other girls.

Following this interview, the school psychologist was able to note a number of stressors that were occurring in Nancy's life, including: 1) Not being allowed to call her grandpa due to the cost involved. She was worried about his health and what he was doing now that he was alone; 2) She had developed few friends. With the exception of a child two years younger than herself, Nancy had established no ongoing relationships with any other children; 3) While her bi-weekly Girl Scout meetings were enjoyable, she had no other activities outside of school which could be considered fun; 4) Because of her mother's work and student schedule, Nancy was functioning as a "latch-key child." She returned home at the end of the school day and normally spent her after-school hours cleaning the house, preparing a part of the dinner, studying or watching television until her mother returned home at 6:00; 5) Because Mrs. R had lost most of her support systems due to the move, both mother and daughter described their relationship as best friends and roommates, Mrs. R had unburdened most of her concerns to Nancy. The child apparently had provided excellent ongoing support for her mother; 6) Nancy had missed the last two weeks of school, including her final exams and other assignments. She was very concerned about making up all her missed work and receiving good grades.

Interventions

The immediate goal was Nancy's return to school. An additional goal was the reduction of apparent stressors with the possible secondary gain of decreasing the recurrent abdominal pains. The following intervention strategies were implemented by the school psychologist, with the help of the school nurse and the guidance counselor:

1. A meeting was held with Nancy's first semester teachers. It was recommended that Nancy be graded only on the work she had turned in up to the point when her two week absence began. She would not be held responsibile for making up any of the work assigned during her absence, nor would she be required to take the first semester final examinations.

2. After discussing concerns with Mrs. R, it was decided that Nancy would be allowed to make a telephone call to her grandfather on a weekly or bi-weekly basis. In addition, Mrs. R was able to plan a weekend visit to the grandfather's home.
3. It was recommended that Mrs. R, with Nancy's assistance, attempt to locate additional leisure activities within the community. After school classes were found for gymnastics and volleyball.
4. Nancy's gymnastic and volleyball class met two nights after school. On the other three school nights, it was suggested that she arrange activities with other children or get involved in school activities rather than returning home directly. The goal was a maximum of two nights per week when she would be expected to function independently.
5. It was strongly recommended to Mrs. R that she seek additional nonfamilial support systems for herself. She was encouraged to explore organized support groups such as Parents Without Partners in her attempts to establish a larger social network. Mrs. R was encouraged not to discuss her worries or concerns extensively with her daughter, but rather to find other adults, if possible, who would be able to provide needed support.
6. When Nancy returned to school, it was recommended that she receive weekly counseling with the school psychologist. Discussions during counseling sessions centered on helping her give herself permission to "act her age", allowing time to discuss concerns, providing support, encouraging participation in school and extracurricular activities, and introducing relaxation training when necessary.

In summary, Nancy's situation and behavior were consistent with children described by David Elkind as a "Hurried Child." Nancy was a 13 year old child who was attempting to play the role of her mother's best friend and roommate. She had provided needed emotional support for her mother, who was under a great deal of stress, at the expense of adding to her own stress. At the same time she had assumed these roles, Nancy was functioning with very few support systems of her own. She had lost the ongoing daily support of her maternal grandfather and other friends. She had accepted more household responsibilities and interacted less frequently with other children.

Nancy returned to school and at the present time is doing well in her second semester classes. She is enjoying the participation in the gymnastics class but has quit attending the

volleyball class. She is considering working on the student newspaper during the spring and has willingly attended all counseling sessions. Interestingly, during the counseling sessions, she is less and less the "young sophisticate" and is spending far more time demonstrating age-appropriate behaviors.

Family Problems (Provided by Kay Konz)

Terry was a fifteen-year old high school boy referred for school psychological services by his American History teacher. In the interview with his teacher, concern was expressed about Terry's high risk of failing the class, although the teacher believed that Terry was capable of mastering the material presented. However, the student appeared to have difficulty in staying on task, failed to turn in assignments, and did poorly on tests, although quiz grades and completed assignments were acceptable. Terry was described by his teacher as withdrawn, and infrequently voluntered any information about himself. The teacher had acknowledged some apprehension about the student's introversion, but had no information about his personality, behavior, or interaction style prior to the beginning of the academic year. The teacher wanted help before Terry fell further behind.

In discussing prior attempts with Terry's History teacher, it was mentioned that frequent communication had occurred with the stepmother upon the initiation of the teacher, in an effort to prod Terry into complying with classroom expectations regarding homework. After further inquiry, the teacher added that he had never had any contact with Terry's custodial parent (his father) or the biological mother. Yet, the stepmother had verbalized an intense desire to coerce Terry into complying with the academic demands, so that the teacher believed some attempts were being made in the home setting to remedy the situation. As the description of the stepmother's behavior was suggestive of a high-profile stepparent and family conflict, the teacher was encouraged at that time to direct his communication regarding Terry's school performance to the biological mother or custodial parent.

Assessment Problem

A review of school records was remarkably unremarkable. Terry had been an average student throughout his school career, and no

behavior problems were documented. Standardized tests scores were indicative of adequate acedemic skills. However, his quarterly grade record yielded dangerously low marks in three classes. It was noted that these classes were more highly structured and academically demanding as compared to the courses in which he was achieving appropriately.

Terry was later observed in the American History class, and the data collected were again not significantly deviant. Terry was compliant, appropriate, and his behavior with his peers could be described as detached and aloof, bur socially acceptable. In structured class activities, Terry appeared to be attempting to attend to the instructor, but was observed to be off-task a high proportion of the time. Off-task behavior was not disruptive, however, as he would stare out of the window, or into space, so that frequently it was difficult to determine if he was attending to task or not.

When Terry was asked to meet with the school psychologist, he seemed somewhat frightened and timid. However, he visibly relaxed when the nature of the interview was explained to him and the ground rules were clearly defined. He was reassured of the confidential nature of the interview, but was still somewhat uncommunicative.

Terry acknowledged that he was not a person who talked a lot, although he did talk freely with his mother and friends. Therefore, he was asked to work on a sentence completion task, to provide the psychologist with more information about him, and he did so willingly. The follow-up discussion of Terry's responses to that task suggested that he had some awareness of his academic difficulties as being an artifact of the parental divorce. He then participated willingly in a description of the current family constellation and then constructed a family genogram. Through that process, it was hypothesized that, in spite of Terry's chronological age, he was functioning psychologically at a "late latency" developmental level, at least relative to the parental separation, divorce, and paternal remarriage, which had occurred all in the past year. That is, Terry demonstrated some intense anger about the drastic family structure changes, particularly in reference to the transition from being an only child who had received much attention from his mother, to his current situation with his father, stepmother, two stepbrothers, and weekend visits to his mother. Terry admitted to acting-out in the home setting, and alluded to some feelings of betrayal, conflicted loyalties, and bruised self-esteem, which are also

symptomatic of a late latency child, post-divorce variety. Further, Terry indicated some anxiety about his mother, since her move out of the house, as well as the formation of a collusion with his mother against his father and some feelings of helplessness, a sense of lacking control over his life.

Intervention Planning

Through the assessment process, it seemed likely that Terry would not respond quickly to traditional psychotherapeutic intervention. While he did express some interest in receiving some support, he rarely initiated conversations or asked questions. (Only after several sessions did Terry feel comfortable enough with the school psychologist to introduce a topic for discussion. At that time, he showed interest in obtaining skills for problem-solving with his parents on the issues of time-sharing and custody arrangements.)

A menu of alternative coping strategies was listed for Terry with each session. These included: support groups, family education programs, reading materials, and family meetings. But, above all, Terry was encouraged to write. Based on his difficulty with verbal self-disclosure, and the emotions communicated in the written format on the sentence completion blank, it appeared that the written mode might be a viable cathartic method for Terry, as well as a "safe" non-threatening vehicle of communication. So he wrote about the divorce for the school psychologist. He wrote letters to his mother. He wrote notes to tell his father about situations at home that he wanted to address. And he said that it made him feel better.

A supplemental intervention technique was to meet individually with Terry's teacher to assess his status in those classes and agree on expectations for successful completion of class requirements. Terry's teachers were empathic and cooperative, and the school psychologist served temporarly as a monitor of the academic demands, in order to relieve Terry's stepmother of that responsibility until it could be renegotiated, and thus eliminate one area of conflict in Terry's relationship with his father's spouse. This strategy also had a positive effect on Terry's relationships with his teacher. They became aware of the turmoil and chaos in his life, which included the adjustment to the loss of his mother from his daily life, the dissolution of the marriage, and the assimilation of a new parent and siblings in his home. A Hawthorne effect seemed to emerge, in that his teachers, without being aware of it, were more

attentive to Terry, became able to anticipate his needs, and provided him with sufficient support, direction, and reinforcement to successfully complete the academic year.

Resulting Problem

After Terry was able to identify some of the issues operating in his academic and family problems, and able to implement some strategies to cope with this adjustment period. the parental divorce was still a powerful issue that needed resolution. Through the intervention process a need emerged for divorce education, particularly regarding time-sharing, the role of the stepparent, and a need for improved communication between the two households. A divorce education program was described to Terry, and he was asked to consider this alternative for his own family. To reduce the feelings of helplessness that are concomitant with a child's reaction to a divorce, Terry was given many of the choices about presenting this program as a potential resource to his parents. Upon Terry's request, the program was discussed to his mother, as well as to his father and stepmother, in two separate staffings scheduled by the school psychologist. Both parents were provided with brochures which describe the divorce education program as well as the reasons for the referral. Both parents were receptive to the recommendations regarding Terry's needs, as well as the educational program. Following the completion of that training experience, Terry's mother accepted a referral for outside counseling, in order to deal with her own issues regarding the dissolution of the marriage. Terry's stepmother refused a referral for marriage counseling for herself and Terry's father.

As with any significant loss, it takes a long period of adjustment before a family divorce is accepted by the individuals involved. This loss seems even more traumatic for the children involved, since frequently they were not prepared for it, had no control over it, and didn't want it. Therefore, the need exists for more support groups for the children coping with a divorce. School personnel need to become more aware of the needs of these children, as they struggle through the transition of a dissolving family structure. Increased sensitivity by school personnel and other helping professional can assist in alleviating the turmoil endured by a child whose parents have divorced. It is possible that the academic and social problems exhibited by children whose parents are divorcing could be substantially lessened if child-service professionals were more aware of the nature of this conflict for a child, as Terry stated so succinctly.

"I love my Mom and Dad more than anyone in the world. I wish I could live with just Mom, or Dad, and not with his wife and her kids. I would mind, but I could live with just living with Mom alone or Dad alone if they didn't want to get back together. I haven't tried to get them back together, I want them to do what they want. All I care about is their happiness. . . But if I live with Dad, it makes Mom unhappy, and if I live with Mom, it would make Dad unhappy. I wish I didn't have to do without one of them. I don't want the divorce to ruin my life or theirs. I don't know what to do. . . . . "

Conclusions from the Case Studies

As has been seen above, the varying crises that have been presented to school psychologists for resolution share a number of common strategic points. The choice points for the professional and the child resemble those provided by writers in the crisis intervention literature. The format for a crisis response appears to be very straightforward. As with many events that appear straightforward, the reality is much more complicated.

The response of a school psychologist to a child in crisis involves immediate attention to the child, confirmation with parents and teachers of the extent of the crisis, gathering of information that clarifies or resolves questions about the crisis, and close collaboration with the child, parents, school, and appropriate community agents in developing an intervention. The skills of the psychologist throughout the crisis response are many and varied. The psychologist brings to bear expertise in communication, data gathering and assessment, direct services to the child, family, or school staff, and skill in eliciting collaboration from all affected parties. At all times, the psychologist is conscious of the fact that he or she may not be the best person available to deliver each appropriate service. Referral to other agencies is an alternative at all times. Given the need for a quick response, referral can occur at the first contact between the child and the psychologist. Similarly, referral can occur throughout the duration of the services delivered by the professional. As discussed earlier, the psychologist under any circumstances can assume the role of case manager in documenting and evaluating the full range of services being delivered to the child and family.

Life-Space Interviewing

A service alternative that deserves separate consideration because of past successes by school psychologists is that of life-space interviewing. A brief description of the service option will assist the professional in recognizing the validity of the intervention during crisis situations. The Department of Public Instruction, through Project Iowa, has supported the development of life-space interviewing training materials that are available to interested school psychologists. Print materials supporting the videotape are provided in Appendix B. (Further information on the tape is available from Stewart Ehly, the University of Iowa)

The life-space interviewing (LSI) technique was developed by Redl (1959) to assist professionals in working with children who were upset. The sequence of applying LSI follows a general pattern:

Step 1. Investigate the child's perception of the problem. How does he or she understand what has just happened? Listen, without interruption, to the child's perceptions and feelings about the event.

Step 2. Test for the depth and the spread of the issue. Is this upset an isolated incident, or does the same kind of things happen to the child very frequently?

Step 3. Clarify the exact content of what occurred. Accept nonevaluatively the child's story, but ask specific questions.

Step 4. Enhance the child's feeling of acceptance through very careful listening. Try to recognize the feelings behind what the child is describing and accept the feelings without necessarily accepting the behaviors.

Step 5. Avoid the early imposition of your value judgments. It is better simply to explore how the child saw the situation and contrast that to the ways in which others may have seen it. Ask what feelings were experienced and how those feelings are

sometimes (if ever) controlled so that no dysfunctional behaviors are emitted. Strategies for self-control and other coping skills can be taught at this point when the child is helped to see the consequences and implications of the nonadaptive behaviors. Right versus wrong or other moralizing statements should be avoided, as they will likely lead to arguments. Most children know right from wrong. Preaching to them will probably make them too defensive to learn anything from the interview.

Step 6. Explore internal mechanisms and possibilities. Ask, "What will help?" "How can I help?" Discover if the child is feeling anxious, guilty, or just sorry about being in trouble. Some of the values that the child may hold can be "massaged" to set the stage for some resolution.

Step 7. Two types of resolution can be attempted. First, the adult presents his or her view of the situation if there is still a need to inject some "reality" into the child's thinking. This may involve describing consequences, behavioral standards and expectations that exist for everyone, and the responsibilities of adults to oversee behavior. The second part of the resolution is trying to develop a solution to the problem that may prevent such disruptions in the future. A solution should not be vague threats or unworkable plans. Specific feasible plans for a change should be made that preferably involve others in the child's environment. In this way, solid support for behavioral changes can be built. LSI may be just the first step in involving other people more positively in the child's life. (Adapted from Morse, 1965)

With life-space interviewing, the school psychologist can explore events that affect the child in daily life. The exploration can focus on any of a number of issues within that child's emotional and social interactions. Through LSI, the professional also can provide what Redl calls emotional first aid. LSI is not intended to be any form of ongoing therapy, but rather an immediate response to assist the child to adjust perceptions of surrounding events.

The LSI option is a valid one for the school psychologist. Expertise in providing LSI will enable the professional to more effectively elicit information from the child involved in a crisis situation. Consult additional resources on LSI and the available videotape for a more elaborate explanation of the LSI option.

Crisis Management in a Rural Area

Earlier in the handbook, the notion of rural school psychological services was raised. In a recent article in the Best Practices in School Psychology, Benson (1985) acknowledged the challenge of rural services under the best of conditions. In such locales, Benson acknowledged lack of special programs for children who have unique needs and lack of community attitudes to support services delivered. When a crisis mobilizes the community in support of a child and family, the psychologist is working with a very potent ally. When the community, however, does not mobilize and support the family crisis, the professional faces difficulty in developing crisis interventions. When professional services do not exist in the community to reinforce family systems, the school psychologist may be the only person available and interested in working with the child or parents.

Other forms of crisis, such as natural disasters, will affect an entire community and, by so doing, involve mobilization of everyone to remedy problem situations. In a recent case in Iowa, a tornado destroyed a large number of farms in a small rural area. The available school psychologist was very interested in following up on the social and emotional reactions of the children who experienced the event. As the community reacted to remedy physical property damage, the professional found everyone more than willing to assist in the documentation of the children's adjustment to the event. More than a year later the community is still very aware of the impact of the tornado on the children and adults in the community and has been very supportive of the school psychologist's efforts.

The rural school psychologist may find valuable the orientation described previously to crisis events, but will need to make adjustments to his or her response because of the lack of the available facilities and professionals to assist during service delivery. In Iowa, with the Area Education Agency concept, rural services are much more elaborate than are found in many other states without a similar arrangement. The Area Education Agency format allows for a quick and varied response to children and families in crisis, given that agency personnel are asked to be involved.

Closing Comments

This handbook and accompanying tape were developed to assist the school psychologist to expand awareness of the options available during crisis intervention. We have seen that very different crisis events can be addressed in similar ways. Establishing control of the environment, gathering and verifying information about crisis circumstances, involving other interested adults (from parents to colleagues), and contracting for change are the immediate steps considered as the psychologist meets with a child. More formal planning for change, implementation of an intervention, and evaluation of change efforts follows as the immediate stressors are removed or controlled.

The continued reference to the school psychologist as case manager during crisis intervention will be repeated in closing. The psychologist has the expertise and the flexability to address both the direct and indirect service needs contained in any crisis situation. When services are delivered by other mental health professionals, the school psychologist can assume responsibility for coordination and evaluation for the full range of interventions that are implemented. Follow-up attention to the child and parents may alert the psychologist to new and continuing needs for service.

Experience as a case manager or change agent during crisis intervention can build on the materials described within this handbook. As a professional striving to the highest standards of ethical conduct, the school psychologist will continue to investigate models and tactics to accomplish effective crisis intervention. The pursuit of such a level of competency is a career-long process.

Additional Resources for the School Psychologist

In addition to the many references contained earlier in this handbook, there are other important components of literature on crisis intervention. Writings on a variety of topics are relevent to the school psychologist faced with choices of assessment, intervention, and crisis management. The following materials contain information directly applicable in crisis situations. The materials can be used to structure both the process and products of school psychological services. Each resource will be described briefly.

Biklen, D.P. (1983). Community organizing, Theory and Practice. Englewood Cliffs, NJ: Prentice-Hall.

In Biklin's contribution to the literature on change, he has developed the theory and practice of community intervention to a high level. He discusses the dynamics of power in bringing about change, the ways in which social problems become forces in the lives of people, and the role of the change agent in bringing about revisions of the norm. Of direct use to the psychologist is his discussion on social protest and legal advocacy. He pursues practices of lobbying, negotiating, and action research, arguing that to effect change in an optimal fashion, the professional must have awareness of forces that influence the status quo. Many of the problems, such as sexual abuse, suicide, and self-abuse, that we have discussed in this text are influenced by forces operating in the broader society. Biklen would argue that to change the broader society, the psychologist and other concerned citizens must take a pro-active stance to produce new realities.

Brammer, L.M. (1985). The Helping Relationship, Process and Skills,3rd edition. Englewood Cliffs, NJ: Prentice-Hall.

Bremmer's text on the dynamics of the helping relationship is a useful resource for any psychologist. Bremmer discusses elements of successful helping, and describes those behaviors of helpers that can bring about effective change. He looks closely at the verbal and non-verbal skills under the control of any helper. He devotes special attention to skills during loss and crisis events. He encourages the reader to use skills for

positive action and behavior change. Finally, Bremmer provides suggestions for how the professional can become more skilled in terms of helping behaviors.

Conoley, J.C., and Conoley, C.W. (1982). School Consultation, a Guide to Practice and Training. New York: Pergamon Press.

Conoley and Conoley have developed one of the best current resources on consultation models and tactics. Their discussion of the skills for effective consultation is directly relevant to any discussion of crisis intervention. The psychologist functioning in a crisis often assumes the role of the consultant, working to influence the behavior of third parties who are also involved in the crisis event. When a direct service to a child is being implemented during a crisis, the psychologist often will be working quickly to effect change in parents or teachers directly involved in current events. Conoley and Conoley promote the use of advocacy consultation to bring about services that may challenge existing norms and expectations in a school. Their discussion of advocacy consultation is an important one, worthy of the attention of readers of this manual.

Duggan, H.A. (1984). Crisis Intervention, Helping Individuals at Risk. Lexington, MA: Lexington Books.

Duggan has developed a recent reference on crisis strategies. Although he channels his arguments in a wide array of professionals, he does provide some insight into crisis circumstances not considered in this manual. His section on collective trauma, the experience of being retarded and institutionalized, and his discussion of interventions into violent situations is worth the attention of all school psychologists. He provides additional discussion on children in hospital settings that helps us better understand crisis intervention involving interdisciplinary action.

Goldstein, A.P., Apter, S.J., and Harootunian, B. (1984). School Violence. Englewood Cliffs, NJ: Prentice-Hall.

Goldstein, Apter, and Harootunian provide an additional resource on options available during violent situations. Their text is an important one in integrating the several theories developed to explain violence with resources that can be devoted to effect change. Although not all violent situations qualify as crisis events, the text is excellent for professionals interested in exploring alternative approaches to intervening at the

violence is a broad one, and a professional needs to become aware of the complexity of violent events.

Meichenbaum, D., and Jaremko, M.E. (Eds.), (1983). Stress Reduction and Prevention. New York: Plenum.

The literature on stress and coping is an extensive one. The text by Meichenbaum and Jaremko does an excellent job of reviewing models of stress and coping and discusses specific interventions to bring about change in individuals. Discussions on stress innoculation and stress innoculation training are informative to any psychologist. The authors collect materials from individuals in medical, military, and mental health settings. Their discussion of work with adolescent anger ties in nicely with the topic of this manual.

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Appendix A

Signs and symptoms of incest

Cues in Father-Daughter Incest

Blurring of generational lines
- Father takes "child" position
- Mother takes "child" position
- Daughter takes role of "mother" and "wife" in family
- Father acts as suitor to daughter
- Mother acts as rival to daughter

Father jealous of daughter's being with peers and dating
Father over-possessive daughter
Father often alone with daughter
Favoritism by father toward daughter over other siblings
Siblings jealous of daughter chosen by father
Daughter depressed
Daughter has poor self-image
Daughter withdrawn
Daughter uninvolved in school activities; grades may fall
Daughter secretive
Daughter excessively seductive
Physical cues:
- Pregnancy
- Venereal disease, genital infection, lacerations, abrasions, bleeding, discharge
- Stomachache
- Painful discharge of urine

Cues in younger children:
- Bedwetting
- Hyperactivity
- Altered sleep patterns
- Fears or phobias
- Overly compulsive behavior
- Learning problems
- Compulsive masturbation
- Precocious sex play
- Excessive curiosity about sex
- Separation anxiety
- Seductiveness

Cues in Brother-Sister Incest
Brother and sister behave like boyfriend and girlfriend
Sister fearful of being alone with brother
Brother and sister embarrassed when found alone together
Sister antagonizing to brother; brother does not retaliate

Taken from The Broken Taboo by Blair and Rita Justice (1979)

CHILD ABUSE RESOURCES IN ONE COMMUNITY

Hot Lines (Cedar Rapids)

398-3950 Linn County Department of Human Services (8am-5pm) to report suspected child abuse.

1-800-362-2178 Iowa Department of Social Services-anytime to report suspected child abuse.

396-7233 St. Lukes-Child Safe-child management questions.

362-2174 Foundation II-crisis counseling

363-2093 Women's Shelter-temporary shelter for abused women and children.

364-1010 Information and Referral-agency information

364-3358 Parents Anonymous-parent support group (child abuse)

643-2532 Parents United-family support group (sexual abuse) (West Branch)

Written Material on Sexual Abuse

He Told Me Not to Tell-King County, Washington (for parents and teachers)

Your Children Should Know-Colan and Hasanshy (for parents)

No More Secrets for Me-Oralee Wachter (for children)

Stranger Danger-(for children)

Films

Better Safe than Sorry-A.E.A.

Who Do You Tell?-A.E.A.

Some Secrets Should be Told-A.E.A

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Books on Sexual Abuse

COME TELL ME RIGHT AWAY, Linda Tschirhart Sanford. Publisher, Ed-U Press, Inc., P.O. Box 583, Fayetteville, NY 13066.

THE SILENT CHILDREN, Linda Tachirhart Sanford. Publisher, McGraw-Hill Paperbacks, 1221 Avenue of Americas, New York, NY 10020.

CHILDREN NEED PROTECTION, Publisher, Carver County Program for Victims of Sexual Assault, 401 East 4th St., Chaska, MN 55318.

NO MORE SECRETS, Caran Adams and Jennifer Fay, Publisher, Impact Publishers, P.O. Box 1094, San Luis Obispo, CA 93406.

"HE TOLD ME NOT TO TELL", Publisher, King County Rape Relief, 305 S. 43rd, Renton, WA 98055. Phone: 205-226-5062 (business), 202-226-RAPE (24-hours).

CHILDPROOF FOR SEXUAL ABUSE, Early Childhood and Parent Specialists. Publisher, The Parent Education Center of Yakima, WA 98908.

SPEAK UP, SAY NO!, Elaine Krause, Publisher, Krause House, P.O. Box 880, Oregon City, OR 97045-0059.

FOR PETE'S SAKE, TELL!, Elaine Krause, Publisher Krause House, P.O. Box 880, Oregon City, OR 97045-0059.

MY VERY OWN BOOK ABOUT ME!, Jo Stowell, Ma.M.ED. and Mary Diatzel, RN., M.S.W. Publisher, Rape Crisis Resources Library, Luthern Social Services of Washington, N. 1226 Howard, Spokane, WA 99201. Phone: 1-509-327-7761.

YOU BELONG TO YOU, A COLORING BOOK, YMCA Domestic Violence/Sexual Assault Services, 310 East Third St., Flint, MI 48502. Phone: 1-509-327-7761.

PRIVATE ZONE, Frances S. Dayee. Publisher, The Chas. Franklin Press, 18409 90th Ave W., Edmonds, WA 98020.

SOMETHING HAPPENED TO ME , Phyllis E. Sweet. Publisher, Mother Courage Press, 224 State Street, Racine, WI 53403.

RED FLAG, GREEN FLAG PEOPLE, Joy Williams. Publisher, Rape and Abuse Crisis Center of Fargo-Moorehead, P.O. Box 1655, Fargo, ND 58107. Phone: 701-293-7273.

Appendix B

(Provided by Archie McKinnon)

Life Space Interview

This is a technique for assisting children in the management of their behavior. The technique was initiated at Pioneer House, near Ann Arbor in the early 1940's, by Fritz Redl who ran Pioneer House which later became The University of Michigan's Fresh Air Camp. The camp has been used for a number of years to train students and to assist problem children during summer sessions. It has been directed by a number of people from various disciplines who were primarily interested in understanding children's behavior and assisting children with the management of their behavior.

The life space interview fits within the psycho-educational framework or model. Knowledge of psychological principles and the child are combined to help the child learn new ways of managing his or her behavior.

Life space interview materials may be easy to read, but extensive practice is needed to promote successful application. LSI provides teachers and others who work with children an outline for concrete action for talking effectively with chidren, providing control, and learning or gaining information from the child. Some assumptions of the life space interview are:

1. that verbal assistance can help the child control his behavior (or manage his behavior).
2. that the life space interview can mediate between the child and the role life holds for him.
3. that greater awareness of reality increases coping ability or ability to control ourselves in relationship to the environment.

Originally the life space interview was called a marginal interview, on the margin of therapy and on the margin of other events within which it takes place. The interview is built around or within the child's direct life experiences, in

connection with issues which become the interview focus.

The adult or teacher who becomes involved in LSI is perceived by the child to be part of the life space. The adult has a clear role and his or her power and influence are to be understood.

The LSI involves an interview with a child immediately following a crisis situation in which the child has been involved. The goals of the interview are to help the child understand feelings and motivations, how these feelings influence others, and to consider the factors that played a part in the immediately preceding crisis situation.

The adult in the situation is assuming responsibility for helping the child understand behavior, is not critical, and does not make moral judgments. The effort is to assist the child in overcoming the immediate conflict or crisis. LSI may only require removal of the child in an antiseptic way (i.e., sending the child on an errand) so that neither he nor the rest of the class becomes too contaminated by the activities or crisis.

Redl contends that interviewing plays an important part in the educational setting. It provides an opportunity for the teacher to mediate between the child and the child's environment or what is expected of him. The interview beyond the mediation role also serves as a useful clinical tool.

Dr. Redl has raised some of the issues surrounding the interview technique and promoted greater objectivity. He discussed LSI in terms of emotionally disturbed children and made an effort to delineate between therapeutic interviews carried on by psychiatrists, psychologists, social workers,and so on. He was and is seriously interested in how the regular or usual classroom teacher can assist children with behavior problems. LSI is advocated for the teacher, and for use in rooms for emotionally disturbed children. Life space refers to the room, school, or environment of a particular child at a particular time.

Dr. Redl's orientation is psychoanalytic. The life space interview provides a specific verbal assistance to children in specific moments of their interaction with the surrounding habitat, and helps them react appropriately and realistically when confronted with similar future problem situations. The life space interview has two uses:

1. emotional first aid on the spot.
2. clinical exploitation of life events, which requires--
   a. skills of interviewing.
   b. knowledge of child's background.

In the teaching situation emotional first aid occurs more frequently and involves (using Redl's terms):

a. Draining Frustration Acidity:
   Help the child handle frustration and tension - help him handle something that can't be helped, i.e., help the child out if he is having trouble getting in his locker, carrying too many books, etc. If an unexpected disappointment comes up, provide something as a substitute. In school, other instances may include giving up a pleasurable activity like recess because a schedule says so.--Children like adults don't like this.-- Sometimes it is enough to verbally recognize the anger and frustration involved. This can drain some of the acidity or potency for eruption from the situation.

b. Providing Support for Management of Panic:
   In moments of panic, guilt, rage, or fury, it is difficult for children to manage their feelings - especially more disruptive or violent ones. The teacher or adult in the situation helps keep things in focus. An extreme example might be the panic children feel when subjected to bombings and necessary evacuation from their homes. Anna Freud and D. Burlingham in War and Children found that those children who managed to remain with their mothers and gained support from them were least upset by either bombing or evacuation. Some of the conservation of the school system and structure provides support to children. The principal is seen as the person who can manage the ultimate - even though modern ideas attempt to remove the principal from this role and for some children the principal fulfills a very useful and necessary role.

c. Maintenance of Communication:
   Maintenance of communication in moments of relationship decay - keep child in contact with reality. This is more related to the emotionally disturbed child who can lose reality contact . . . . it requires that the teacher or other adult make every effort to maintain communication in relation to activities.

d. Regulation of Social and Behavioral Traffic:
Help child organize social response regulating and the control function. We can point out the rules and regulations in a given situation - and the consequences if the act occurs again.

e. Umpire Services:
Mediate inner and outer conflicts. (fights, etc.). This is essential in the school situation where children's feelings may govern their action's and some mediation is in order. One teacher described a child in a game in which on his knees, he was to use his shoulders to push another child off a mat. As she turned away for a moment and turned back she saw one child about to land on another child's hand with his knee in an effort to loosen the first child's grip on the mat. Some umpiring was in order.

f. Group Psychological Suction-Student can be manipulated by others:
He is affected by the feelings of the group - group may be sad and he has to liven it up. Help child see what happens in a number of incidents so he gets some insight into how he gets "sucked in." Help a student make a decision by discussing alternatives.

The second goal of the life space interview is CLINICAL EXPLOITATION This is an attempt to think in terms of a longer range and perhaps therapeutic goal for a child as contrasted with the immediacy of EMOTIONAL-FIRST AID. This particular use is compatible with today's thinking in terms of individualized instruction. It would be most appropriate to individualize instruction in the affective or emotional area. You can assess the needs in this area - or diagnose the needs - describe short and long term goals - and work toward their attainment. Some of the techniques the life space interview can provide include:

1. Reality Rub-In
The counter-distortional interview is an effort in this direction. Children may not know the meaning of an event unless it is pointed up in large letters for them. Sometimes they need to be focused on the reality of a situation. The earlier example from emotional first aid on umpiring is appropriate -- the umpire tends to the immediate situation. The reality rub-in extends the situation to help the child understand the realities

involved in particular actions, such as injury, feelings, and the need for control.

2. Symptom Appropriateness - or Estrangement
Pick behavior or issues that help child see that his behavior is strange. You look for or are more aware of child's life experiences that point up the inappropriatness of his behavior. Using the counter-distortional interview you would file in your memory instances of appropriate and inappropriate behavior.

3. Massaging Numb Value Areas:
Increase intensity of child's own sense of wrongness. Use areas that are appropriate to child's own life space in which he lives. With child mentioned earlier about to jump on another child's hand, raise values child displays - contrast with value that you don't deliberately injure others.

4. New Tool Salesmanship:
Increase child's repertoire of reaction techniques. This is an especially appropriate technique for the school setting and only means that you help the child learn new methods of handling the situation. One way is to discuss the situation with the child for ideas he may have - another is to suggest some appropriate behavior - another is to read a book written about a behavior and discuss with total class group - another is to open up the kind of behavior to class discussion.

5. Manipulation of Boundaries of Self
Sharpen child's autonomy. Help him understand his own self-values. We let children know the boundaries of their reading ability but not often the boundaries of their affective selves. Why can't we observe that "after you have worked on 4 problems you get frustrated" so do something else and come back and finish the problem. In a reading session during tutoring, a 9- year-old got up and ran from one side of the building to the other and sat down to work with his reading again -- he knew his own boundaries. We all have them - hopefully as we grow and understand more our boundaries expand, too.

Criteria for using the life space interview or indications or contraindications for using the L.S.I.:

1. Ego Proximity - deeply repressed material is avoided - other issues may need to be handled because of ego proximity - because they are so ego involved.

2. Issue Clarity - need to sort out the issue involved so child can see it clearly.

3. Timing - flexible - do it right now when the incident occurs - or wait until the child cools off and talk with him.

Other considerations:
Where did the issue occur; was it clear cut; was it dangerous; how much awareness does the child have of his behavior; when did behavior start; what events are influencing behavior? What affect accompanied behavior; what is relationship of behavior to his background; can child tolerate working through the behavior at this time; how many times has he already been discussed with by someone? What are you competing with?
Role Compatibility, Mood, Terrain, and Props.
Does L.S.I. fit in with your role as viewed by the child?
Would someone else do a better job with him?
Does the setting amplify resistance or is it neutral?
What are the other children around doing? How do you feel?

The kinds of things to be concerned with as you enter the life space interview:

CONTENT:

Diagnosis of Problem:
1. Peer Relationships
2. Adult Relationships
3. Home Problem
4. Characteriological Problem
5. Management Problem

A characteriological problem means that it is a problem of long standing and imbedded in the way a child acts toward life situations generally. This kind of a problem usually requires consistent and repetitious reality rub-in.
The management problem may be more easily handled since it probably is not so imbedded and will respond to relationship and discussion. Confusion of the two can result in a difficult situation.

The life space interview may begin with some of the following behaviors:

1. Defensive Behavior--silly, giggling, crazy behavior
2. Frightened or withdrawn behavior
3. Maintain or gain power--need to control adults, omnipotent defiance.
4. Manipulative--seductive, meek, contrite, promises
5. Embarrassed or ashamed, may indicate deeper problems

Suggested responses by professional:

1. Serious--in order to offer student a backdrop for his behavior
2. Reassuring
3. Firm
4. Indicate your awareness

Techniques for interview:

Direct appeal to the sense of logic or reason.
Reality testing--help child mediate own behavior.
Ex. Boy calls boy names--raise question what did you think he'd do?
Dialogue--you verbalize for the child--communicate feelings to the child.
Limit setting--firm insistence.
Re-enactment of the crime--bring evidence and witnesses.

Goals of the life space interview:

1. Develop awareness of own inner feelings.
2. Express feelings more appropriately.
3. Develop new habits and relationships.
4. Build up self-identity and self-esteem.
5. Help him perceive adults correctly.

After the interview you will want to provide some closure and return the child to his life orbit.

You have provided some repair or restoration of the child to a more normal behavior; you have reached some mutual agreement regarding the difficulties . . . . Return him to environment and express positive and affectionate feelings to him.

Crisis Intervention - Life Space Interview

One of the basic tenets of crisis intervention is that when a crisis occurs there is a breakdown of coping skills and a corresponding output of energy looking for a resolution. The literature shows that the interest in some resolution to the crisis is higher and a resolution is more useful when it occurs if it is closer to the crisis. This can vary with individuals, situations, and crises; i.e. at certain age levels crises don't last long and are easily forgotten; or with most acting out aggressive children, the crisis is gone and forgotten not too long after it occurs. Some individuals need a cooling off period and others do not benefit from one in terms of its usefulness to the crisis resolution. Sometimes it is better to use the energy generated by the crisis in efforts toward immediate resolution. There is no substitute for knowing the individual student well, but change can be assisted by the need for resolution at the time of the crisis.

The person who has the responsibility for effecting a resolution of the crisis is most effective if immediately available and aware of the factors involved with the crisis. The teacher is especially effective in crisis intervention since the teacher is immediately available and is usually aware of the factors involved with the crisis. A related instance is the use of live-in social workers to help alcoholics manage the crisis that occur as they are working to overcome their alcoholism. And the use of live-in social workers to help parents manage crises which occur in the home when there is a severely disturbed child in the home setting.

When a Crisis Occurs in Class

Teachers have the following knowledge base:

1. Knowledge and understanding of the child
2. Knowledge of the class, its purpose, structure, and climate.
3. Knowledge that at the time of crisis there is an energy output and a need on the part of the student to resolve the crisis.
4. Knowledge of the situation and factors involved with the

crisis. Or at least these can be readily attained.

5. A technique for crisis resolution or for intervention at the time of crisis.

The life-space interview is suggested as such a technique. This is one intervention technique that has shown positive results with a variety of children from early elementary through secondary grades in school--and with a variety of children in camps and institutional settings.

However, it is a tool and not a panacea. It is not useful for all situations or all children.

Assumptions Made Prior to Intervention

1. The child is having the crisis; the teacher is not having the crisis beyond the usual apprehension attending any crisis situation. (However, the teacher may be experiencing a crisis and may need consultation with life-space interviewing.) If we are intervening in a student's crisis with a life-space interview, we should establish that this is the student's problem and not our own.

2. The classroom setting or program permits use of the life-space interview, i.e., you can take time from the other students to resolve the crisis.

3. The teacher is familiar enough with life-space interview to use it easily at the time of a crisis.

Although not an assumption, the opportunity to discuss the crisis and the resolution with a consultant can help the teacher learn more about behavior problem resolution in the classroom.

The Life-Space Interview with the Student

The life space interview provides someone to help children achieve acceptable behavior so they can cope with the stresses and demands of the school setting. Even in a severe crisis situation, this may be all that is needed or that the child can use at a given point in time, i.e., the child who begins to cry in the classroom and you know a parent is seriously ill; you

rescue the child from the classroom setting, provide support, empathy, and verbalize understanding of his feelings so that he can return to the school tasks that may provide some success and feelings in contrast to the crisis situation he must live through at home.

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Life-Space Interview format

Student's Name:_____
Date: _____
Teacher's Name:_____

1. What happened? (just prior to the incident)
   Elaboration:

2. Is the reaction frequent? If so, what is the reason for such a reaction? (What is the basic central issue involved)
   Elaboration:

3. What happened in sequence? (no judgments)
   Elaboration:

4. Empathize with the child's feelings.

5. What are the implications of the behavior exhibited? How does it affect you, others? In what other ways could this situation be handled?
   Elaboration:

6. What can be done to help you with the problem? Can anyone else help you with it? Clarify assumptions made without judgments; only use evidence.
   Elaboration:

   Was issue resolved at this point? Yes ___ No ___

7. What can we do to prevent this behavior from occurring again?
   1 - Adult injects expectations of "real world"
   2 - A plan is developed.
   Elaboration:

MORE ON LIFE SPACE INTERVIEWS

Kitchener, H.L., The Life Space Interview in the Differentiation of School and Residential Treatment.

Kitchener discusses the problems that had to be solved for children who could not differentiate between the ward and the school at the Child Research Branch of National Institute of Mental Health, Bethesda, Maryland.

The first phase of the treatment was to set up the school as a non-threatening entity. Next the children learned to differentiate the present school from the past school settings in which failure had been involved. Interview techniques were used most in dealing with:

1. Props for distraction in school versus need for temporary possession of object presentation; i.e. taking a favorite toy to school.

2. Fear of academic task, as it reveals a deficit.

3. School content-distortions associated to primary process floods or case history-nightmares; i.e. separating the past fears from present situations.

4. Anticipating report cards.

5. Changes in school programs.

6. Extra-curriculum school activities.

7. Homework.

8. Old problems in new settings.

Life space interviewing can help get the child through change. It permits the child and staff to comprehend how the child thinks of himself. And it helps the child to get through such terrifying situations as tests and reports.